

7463

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Larmont</b> Middle <b>Austin</b> Last <b>ALLEN</b>				4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1959</b>	9. AGE (In years lost birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jerome Austin ALLEN</b>				14. MOTHER'S MAIDEN NAME <b>Althea Imelda Frances PROCTOR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital records.</b>		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>763.0</b> DUE TO (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 29, 1959</b> , to <b>July 1, 1959</b> , that I last saw the deceased alive on <b>July 1, 1959</b> , and that death occurred at <b>2:20PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>95 Cathedral St., Annapolis, Md.</b> DATE SIGNED <b>7/1/59</b>							
ACTUAL SIGNATURE <b>Clayton Norton</b>		PHYSICIAN'S NAME (Type) <b>Clayton Norton</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Mercy</b>		22d. LOCATION (City, town, or county) (State) <b>Owensville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7498

## CERTIFICATE OF DEATH

Reg. Dist. No.

07451

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pines on the Severn</u>		e. STREET ADDRESS <u>Pines on the Severn</u>	
3. NAME OF DECEASED (Type or print) <u>Olive Emma Anderson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28-1876</u>
9. AGE (In years, last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Edward S. Lindsay</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Emma Ellis</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Brooks Anderson</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis with fibrillation</u> DUE TO (c) <u>Maternal Arterial Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>About 18 hrs</u> <u>A year or more</u> <u>Proximal</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5-</u> 19 <u>59</u> , to <u>7-19-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7-19-</u> 19 <u>59</u> , and that death occurred at <u>5:45</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Oliver Purvis</u>		ADDRESS (Street, city or town, state) <u>40 Franklin Ave, Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>J. OLIVER PURVIS</u>		DATE SIGNED <u>7/20/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rural Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Albany N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr.</u>		ADDRESS <u>Carmapolis Md.</u>	
74a. REC'D BY REGISTRAR DATE <u>JUL 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Kraus</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07452

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A.A. Co.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) _____ c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.D.A. - A.A. Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P.G.</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u> <span style="float: right;">16X-2</span> d. STREET ADDRESS <u>Church Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>Arnold</u> Last <u>Jr.</u>		<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>18</u> Year <u>1959</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>C</u>			
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12.13. 1914</u>		<b>9. AGE</b> (In years last birthday) <u>44</u> yrs. <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Public School</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>George T. Arnold, Sr.</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Eleanor Quander</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.# 2</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>214-40-5590</u>				<b>17. INFORMANT</b> <u>Mrs. Rachel Pemberton</u> <span style="float: right;">4035 Webster St., N. Brentwood, Maryland</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury Anterior Chest</u> <u>825X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - R301</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>7-18</u> p. m. <u>1959</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
<b>20f. (City or town)</b> <u>MAco</u>		<b>20g. (County)</b> <u>MD</u>		<b>20h. (State)</b> <u>MD</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>E. Linhardt</u>		<b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>7-18-59</u>			
<b>EXAMINER'S NAME (Type)</b> <u>E. Linhardt</u>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>					
<b>22b. DATE THEREOF</b> <u>7.23.59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Srlington Nat'l. Cem.</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Arlington, Va.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert G. McGuire</u>							
<b>ADDRESS</b> <u>1820 9th St., N.W. Washington, D.C.</u>							
<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUL 22 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Carlton S. Throckmorton</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7499

CERTIFICATE OF DEATH

Reg. Dist. No.

07453

1. PLACE OF DEATH a. COUNTY <u>D.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cuth Hill</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glens Burnil</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary R.</u> Middle <u>Baskerville</u> Last <u>Baskerville</u>		4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Dec. 12, 1888</u>	9. AGE (In years last birthday) <u>71 yr.</u>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Cuth Hill, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Elyahuthy Bly</u> Address <u>Glens Burnil, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>TERMINAL BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIO-VASC. DISEASE</u> DUE TO <u>CERT. GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>SENILITY</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> <u>3 YEARS</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u>	Month <u>—</u> Day <u>19</u> Year <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 9, 1958</u> to <u>JULY 20, 1959</u> , that I last saw the deceased alive on <u>JULY 20, 1959</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>		ADDRESS (Street, city or town, state) <u>Mountain Rd.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR MD</u>		DATE SIGNED <u>7-20-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Adventist</u>		22d. LOCATION (City, town, or county) (State) <u>Adventist Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Kelly</u>		ADDRESS <u>1303</u>	
24a. REC'D BY REGISTRAR <u>JUL 22 '59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur Lankford</u>		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

Page No. 1

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1900</i></p>	
<p>5. PLACE OF BIRTH <i>New York City</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>Jan 1 1925</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10 1945</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>	

MASSACHUSETTS DEPARTMENT OF HEALTH  
BOSTON, MASS.

7465

## CERTIFICATE OF DEATH

Reg. Dist. No.

-07454

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>	
3. NAME OF DECEASED (Type or print) First <b>Theodore</b> Middle <b>BEALL</b> Last <b>BEALL</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 11, 1914</b>
9. AGE (In years lost birthday) <b>45 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elec. Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G. &amp; E. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Aloysius J. Beall</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Hüller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-7776</b>	
17. INFORMANT <b>Mrs. Anna V. Beall</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/14/59</b> , 19____, to <b>7/14/59</b> , 19____, that I last saw the deceased alive on <b>July 14</b> , 19 <b>59</b> , and that death occurred at <b>4:55P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>98 Cathedral St., Annapolis, Md.</b> DATE SIGNED <b>7/15/59</b>			
ACTUAL SIGNATURE <b>Edwin Davis, Jr.</b>		M.D. <b>98 Cathedral St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Edwin Davis, Jr.</b>		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 13, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Brooklyn RD Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. Singleton - Glen Burnie, Md.</b>		24. REC'D BY REGISTRAR DATE <b>JUL 20 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hauer</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHURCHMAN OF CHURCH

1888

John A. Church

Churchman

Churchman

Churchman

Churchman

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7500  
CERTIFICATE OF DEATH

Reg. Dist. No. 07455

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MARYLAND</b> <b>Anne Arundel</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>3 years</b> <b>4 mo. 7 days</b>		3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>837 W. Lexington Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Hollie</b> Middle <b>Bell</b> Last <b>Bell</b>		<b>4. DATE OF DEATH</b> Month <b>7</b> Day <b>12</b> Year <b>19 59</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9/18/1913</b>
<b>9. AGE</b> (In years last birthday) <b>45</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Ernest Preston</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ellena Nichols</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>	
<b>17. INFORMANT</b> <b>Hospital Records</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Cervix</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>026x Central Nervous System Syphilis</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) -----	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>11:45</b> p. m. <b>19 59</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> <b>While at work</b> <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) -----		<b>20f. (City or town)</b> (County) (State) -----	
<b>21. I certify</b> that I attended the deceased from <b>3/5</b> , 19 <b>56</b> , to <b>7/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/12</b> , 19 <b>59</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>7/13/59</b>			
<b>ACTUAL SIGNATURE</b> <b>L. Benedict, M. D.</b>		<b>PHYSICIAN'S NAME (Type)</b> <b>Crownsville State Hospital, Md.</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>1-15-59</b>		<b>22b. DATE THEREOF</b> <b>7/13/59</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Ignace</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Baltimore Md</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Kate R. Wilhelm</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUL 16 59</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>			

01232

CERTIFICATE OF DEATH

1900

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7466

CERTIFICATE OF DEATH

07456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>York</u> 75 x -3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weems Creek</u>		d. STREET ADDRESS <u>5068 Pershing Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Shower</u> Last <u>Beltz Jr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1936</u>
9. AGE (In years lost birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USAF Band</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Harry Shower Beltz Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Florence Dick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1954-1959</u>		16. SOCIAL SECURITY NO. <u>185-28-1726</u>	
17. INFORMANT <u>Official Air Force Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Drowned while swimming</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0030</u> o. m. <u>##</u> <u>July 17</u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Weems Creek</u>		20f. (City or town) (County) (State) <u>Annapolis</u> <u>Arundel</u> <u>Maryland</u>	
21. I certify that I attended the deceased from <u>NEVER</u> , 19____, to <u>NEVER</u> , 19____, that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>0030A</u> M, from the causes and on the date stated above. Reviewed remains upon arrival - See reverse		ADDRESS (Street, city or town, state) <u>USAF HOSPITAL ANDREWS</u>	
ACTUAL SIGNATURE <u>Heino Trees</u> M.D.		DATE SIGNED <u>17 Jul 59</u>	
PHYSICIAN'S NAME (Type) <u>HEINO TREES MD</u>		<u>WASHINGTON 25, D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-22-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>York, Penna.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home Inc. 816-H ST NE</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 22 '59</u>	
ADDRESS <u>WASH. D. C.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneel</u>	

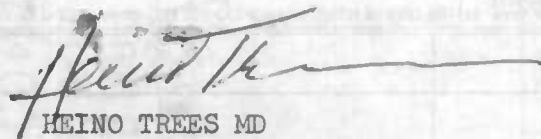
# CERTIFICATE

I the undersigned, Emergency Doctor, USAF Hospital Andrews, affirm that the remains were received from US Naval Hospital Annapolis Maryland at 1300 hours 17 Jul 59.

The Coroner, Arundel County, released remains to service control and desired that the Death Certificate be prepared by service facility performing the autopsy.

Jurisdiction over remains was released to and accepted by USAF Hospital Andrews, Andrews AFB, Camp Springs, Prince Georges County, Maryland.

Cause of death confirmed by autopsy.

  
HEINO TREES MD  
Emergency Doctor

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VS A15 (4)  
15M 9/58

7501 **CERTIFICATE OF DEATH** back of Cert.

Items 3, 13 See note from funeral Dir. on

Reg. Dist. No.

07457

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN TB <b>12hrs. 15min.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>330 Cannon</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Merritt</b> Middle <b>Berryman</b> Last <b>Berman</b>		4. DATE OF DEATH Month <b>7</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/06</b>
9. AGE (In years lost birthday) yrs. <b>53</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Berman Berryman</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes.</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Mitral Stenosis</b> DUE TO (c) <b>-----</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lobar Pneumonia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1/59</b> , 19 <b>59</b> , to <b>7/2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/2</b> , 19 <b>59</b> , and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>7/2/59</b>			
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>		M.D. <b>Crownsville State Hospital, Md.</b> <b>7/2/59</b>	
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		<b>Crownsville State Hospital, Md.</b> <b>7/2/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>James Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Waller</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

Please note - Correct spelling for the deceased  
last name is

BERRYMAN



07458

MEDICAL CERTIFICATION

VS A15 (4)  
ISM 9/SB

80396

UNITED STATES OF AMERICA

80397

RECEIVED

UNITED STATES OF AMERICA

RECEIVED

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07459

7467

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 St. Washington St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles E. Bowie</u>		4. DATE OF DEATH Month <u>07</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1876</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Bowie</u>		14. MOTHER'S MAIDEN NAME <u>Temple Randall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mamie Bowie - Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> 561.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Strangulated Left Inguinal Hernia</u> DUE TO (c) <u>24th</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/19/59</u> to <u>7/19/59</u> , that I last saw the deceased alive on <u>7/19/59</u> , 19 <u>59</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		DATE SIGNED <u>7/23/59</u>	
PHYSICIAN'S NAME (Type) <u>William Beese, Jr. - Annapolis, Md.</u>		ADDRESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u>		22d. LOCATION (City, town, or county) (State) <u>Best Gate, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beese, Jr. - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7503  
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 27 07460

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> 03X-2					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				d. STREET ADDRESS <b>8622 Church Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMIL JAMES BRANDON</b>				4. DATE OF DEATH Month Day Year <b>July 26 19 59</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8 Oct 1892</b>			
9. AGE (In years last birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James Brandon</b>				14. MOTHER'S MAIDEN NAME <b>Corinne Alberta</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>116-12-3491</b>		17. INFORMANT <b>Son</b> Address <b>8622 Church Lane Randallstown, Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 July</b> 19 <b>59</b> , to <b>26 July</b> 19 <b>59</b> , that I last saw the deceased alive on <b>26 July</b> 19 <b>59</b> , and that death occurred at <b>1135AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Army Hospital, Ft. Meade, Md 26 Jul 59</b>									
ACTUAL SIGNATURE <b>ROGER C. MOYER</b>				M.D. <b>U.S. Army Hospital, Ft. Meade, Md 26 Jul 59</b>					
PHYSICIAN'S NAME (Type) <b>ROGER C. MOYER, Capt, MC, U.S. Army Hospital, Ft. George G. Meade, Md 26 Jul 59</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>7-27-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fresh Pond Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Maspeth, Long Island, New York</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				ADDRESS <b>1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knecht</b>	





7468

## CERTIFICATE OF DEATH

07461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Box 273-A Annapolis Neck Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Tyrone</u> Middle <u>Anthony</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1959</u>		9. AGE (In years lost birthday) yrs. <u>9</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u>9</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Archie Curnell Brown</u>				14. MOTHER'S MAIDEN NAME <u>Helen Flontina Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Mother Box 273A, Annapolis Neck Rd., Annapolis Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to</u> (c) <u>Due to</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Md.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>19</u> Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>110 Clay St. Annapolis</u>		(County)	(State)
21. I certify that I attended the deceased from <u>July 7, 19 59</u> , to <u>July 8, 19 59</u> that I last saw the deceased alive on <u>July 8, 19 59</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. R. L. Richardson</u>				DATE SIGNED <u>110 Clay St. Annapolis 7/9/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. R. R. L. Richardson</u>				<u>Clay St., Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer St. Annapolis Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>Arthur E. Hines</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	
ADDRESS <u>2163 2378 Y0</u>				DATE <u>JUL 13 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05181

GEORGE A. E. CLARK

1897

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(2)

(3)

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7469

CERTIFICATE OF DEATH

07462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>1 7 West Elliott Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Buser</u> Last <u>Buser</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1910</u>	
9. AGE (In years lost birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERIES</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>HENRY BUSER</u>				14. MOTHER'S MAIDEN NAME <u>ELISE MOHLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Elizabeth S. Buser (2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial intestinal obstruction</u> <u>197.9</u> DUE TO (b) <u>(operated)</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Malignant Salivary Gland Tumor</u> DUE TO (c) <u>Malignant Salivary Gland Tumor</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 1955</u> to <u>7-9-1959</u> , that I last saw the deceased alive on <u>7-9-59</u> , 19 <u>  </u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				DATE SIGNED <u>7-10-59</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sues</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>Annapolis Md</u>				DATE <u>JUL 13 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
1SM 9/58



7504

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Laurel, Md.</b>		c. LENGTH OF STAY IN 1b <b>1 yr. 4 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>District Training School, Children's Center</b>				d. STREET ADDRESS <b>1322 - 11th St. N.W., Apt. 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marian</b> Middle <b>Elaine</b> Last <b>Byrd</b>				4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/54</b>		9. AGE (In years lost birthday) yrs. <b>4</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Edward Byrd</b>				14. MOTHER'S MAIDEN NAME <b>Barbara E. Law</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT <b>Children's Center, Laurel, Md.</b> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia - partial atelectasis - lft.</b> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>cerebral palsy - rigidity quadriplegia</b> DUE TO (c) <b>mental retardation - severe</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>February 28, 1958</b> , to <b>July 1, 1959</b> , that I last saw the deceased alive on <b>July 1, 1959</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Wilfred R. Ehrmantraut, M.D.</b>				ADDRESS <b>Children's Center, Laurel, Md.</b> DATE SIGNED <b>7/1/59</b>			
PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantraut, M.D.</b>				" " " "			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>7-6-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Mem.</b>		22d. LOCATION (City, town, or county) (State) <b>Anne Arundel Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A M DROSE B. Boyd</b>				ADDRESS <b>1238 - 20th St NW</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 10

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Date of birth: [illegible]

4. Place of birth: [illegible]

5. Date of death: [illegible]

6. Place of death: [illegible]

7. Cause of death: [illegible]

8. Duration of illness: [illegible]

9. Name of attending physician: [illegible]

10. Name of informant: [illegible]

11. Signature of informant: [illegible]

12. Signature of physician: [illegible]

13. Signature of registrar: [illegible]

14. Date of registration: [illegible]

15. Place of registration: [illegible]

16. Name of registrar: [illegible]

17. Date of registration: [illegible]

18. Place of registration: [illegible]

19. Name of registrar: [illegible]

20. Date of registration: [illegible]

21. Place of registration: [illegible]

22. Name of registrar: [illegible]

23. Date of registration: [illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07464**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Meade</u> c. LENGTH OF STAY IN lb <u>One hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Building #4554</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>A.A.</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Gardens, Glen Burnie</u> d. STREET ADDRESS <u>99 Glen Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Jesse J. Cassady</u> First Middle Last				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>15th</u> Year <u>19 59</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10/9/96</u>		<b>9. AGE</b> (In years last birthday) <u>62</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Civil Service</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Blackburg, Va.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>James W. Cassady</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Magdalena Hall</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>World War I</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Elvie Effinger Cassady</u> Address									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a. m. p. m.		Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		(County)		(State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert</u> <span style="float: right;">DATE SIGNED <u>7/15/59</u></span> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>18 July '59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Westview Cem.</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Blackburg, Virginia</u> (State)					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Richard W. Singleton</u>						ADDRESS <u>Glen Burnie, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Arthur L. Kraus</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>		DATE <u>JUL 20 '59</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7470

CERTIFICATE OF DEATH

Reg. Dist. No.

07465

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>COLEMAN</b> Last 4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 12, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Corbett</b>		14. MOTHER'S MAIDEN NAME <b>Celestine Curran</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Robert C. Adams 407 Lakeview Ave, Mayo, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shabik pneumonia, Cerebral vascular accident</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/6</b> , 19 <b>59</b> , to <b>7/7/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/7/59</b> , 19 <b>59</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>121 Cathedral St., 7/7/59</b>	
ACTUAL SIGNATURE <b>Richard N. Peeler</b> M.D.		121 Cathedral St., 7/7/59	
PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b>		<b>Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 10, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert X. Murphy</b>		24a. REC'D BY REGISTRAR <b>JUL 10 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>

07485

CHARTER OF FREEDOM

1215

11

7471

## CERTIFICATE OF DEATH

07466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>15 Years</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Annapolis, Md.</b>			d. STREET ADDRESS <b>107 Clay Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Lewis</b> Last <b>CROCKER</b>			4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-30-01</b>	9. AGE (In years lost birthday) yrs. <b>58</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Rev. Thomas Lewis CROCKER</b>			14. MOTHER'S MAIDEN NAME <b>Belle Rainy Scott</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>U.S. Naval Hospital, Annapolis Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRA-CEREBRAL HEMORRHAGE</b> 33/x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>10 1/2 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>7-24</b> , 19 <b>59</b> , to <b>7-24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-24</b> , 19 <b>59</b> , and that death occurred at <b>6:20 P</b> M, from the causes and on the date stated above. LT MC USNR ADDRESS (Street, city or town, state) <b>US Naval Hospital, Annapolis, Md.</b> DATE SIGNED <b>7-25-59</b>					
ACTUAL SIGNATURE <b>R. I. HOCHMAN</b> M.D.					
PHYSICIAN'S NAME (Type) <b>R. I. HOCHMAN LCDR MC USN</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>		<b>7-29-59</b>		<b>Annapolis Natl. Cemetery, Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Seese, Jr. Annapolis, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>UL 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knead</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7472

CERTIFICATE OF DEATH

Reg. Dist. No. 07467

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural - Severn</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				f. STREET ADDRESS <b>Rt-1, Box-230</b>			
3. NAME OF DECEASED (Type or print) First <b>J ames</b> Middle <b>H.</b> Last <b>CROUSE, SR.</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 18, 1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.		IF UNDER 24 HRS. Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>JAMES H. CROUSE</b>				14. MOTHER'S MAIDEN NAME <b>ANNA M. CROUSE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>				16. SOCIAL SECURITY NO. <b>MR. JAMES H. CROUSE JR.; SAME AS 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gen. Carcinomatosis - primary</b> <b>199.2</b> DUE TO <b>site unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs.</b> (c) <b>2 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 24, 1959</b> , to <b>July 28, 1959</b> , that I lost the deceased olive on <b>July 28, 1959</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Amos Garrett Blvd., Annapolis, Md.</b> DATE SIGNED <b>7/29/59</b>							
ACTUAL SIGNATURE <b>Samuel Borssuck</b>				M.D. <b>Amos Garrett Blvd., Annapolis, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Samuel Borssuck</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baldwin Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Milkersville, AA, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping + KIRKLEY</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral-director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Star

TO HOSPITAL (If attending physician: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.)  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7506

## CERTIFICATE OF DEATH

07468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>4 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		d. STREET ADDRESS <u>2219 N. Howard</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Davis</u>		4. DATE OF DEATH <u>July 1 1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Ethel Johnson Davis</u>		Address <u>2219 N. Howard</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heat stroke.</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-25</u> , 19 <u>59</u> , to <u>6-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-25</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jehes Gruenberg</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Box 37</u>	
PHYSICIAN'S NAME (Type) <u>Jehes Gruenberg</u>		DATE SIGNED <u>7/1/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holsten &amp; March</u>		ADDRESS <u>918 Druid Hill Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	



7473

CERTIFICATE OF DEATH

Reg. Dist. No. 07469

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>x East Port</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A. A. General Hosp.</u>		d. STREET ADDRESS <u>306 Chester Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Davis</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min. <u>9</u>	IF UNDER 24 HRS. Hours <u>9</u> Min. <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cookowner Tavern</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vermont Brown</u>		14. MOTHER'S MAIDEN NAME <u>Alice Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. ADDRESS <u>George Davis East Port</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute myocardial infarction</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2:34 7/25</u> , 1959, to <u>2:35 7/25</u> , 1959, that I last saw the deceased alive on <u>7/25</u> , 1959, and that death occurred at <u>2:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Holman</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral St.</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>		DATE SIGNED <u>7/25/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Neck</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, Jr. Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

063  
Davis  
Emma

VS A15 (4)  
15M 9/58





7474

CERTIFICATE OF DEATH

07470

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>Mecklenburg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>5 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>063 ANNE-ARUNDEL GEN. Hosp.</u>				d. STREET ADDRESS <u>Chase City - 834 3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE ELIZABETH DAVIS</u>				4. DATE OF DEATH Month Day Year <u>JULY 5 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 3-1885</u>	
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Never Worked</u>		11. BIRTHPLACE (State or foreign country) <u>Chase-City VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>							
13. FATHER'S NAME <u>Charles W. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Puryear</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>Dr. HARVEY F. DAVIS</u>				Address <u>ANNA, Md. Rt. 3-Box 181A.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO <u>442X</u> (c) <u>Arterio Nephrosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/30</u> , 19 <u>59</u> , to <u>7/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/5</u> , 19 <u>59</u> , and that death occurred at <u>12:00</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore L. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>37 Calvert Street Annapolis, Md.</u>			
DATE SIGNED <u>July 10 '59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem</u>		22d. LOCATION (City, town, or county) (State) <u>Chase City VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u> ADDRESS <u>ANNAPOLIS-Md.</u>				24a. REC'D BY REGISTRAR <u>Jul 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05170

CERTIFICATE OF ORIGIN

1975



7475

CERTIFICATE OF DEATH

07471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>704 Wells St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Irene</b>		First Middle Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-29-1882</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>David Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Dorsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		INFORMANT Address <b>Ida Holley - Anna. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes Comp. Pulmonary</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Edema of Central Edema</b> DUE TO (c) <b>Arteriosclerosis by pulmonary disease</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 22, 1959</b> , to <b>July 28, 1959</b> , that I last saw the deceased alive on <b>July 28, 1959</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>110 Clay St.,</b> DATE SIGNED <b>7/29/59</b>							
ACTUAL SIGNATURE <b>R. L. Richardson</b>				M.D. <b>110 Clay St.,</b>			
PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-31-59</b>		22c. NAME OF CHURCH OR CREMATORY <b>Centers</b>		22d. LOCATION (City, town, or county) (State) <b>Friendship</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Leese, Jr. - Anna. Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1711

STATE OF NEW YORK  
CERTIFICATE OF DEATH

11

11

1



7476

CERTIFICATE OF DEATH

Reg. Dist. No.

07472

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1808 Lincoln Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Sherman</b> Middle <b>DORSEY</b> Last <b>DORSEY</b>				4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-8-1905</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min. <b>54</b>		IF UNDER 24 HRS. Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min. <b>54</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James G. Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the prostate with metastases to Pelvic &amp; Pericardial lymph nodes and bones of Pelvis &amp; spine</b> DUE TO (b) <b>177X</b> DUE TO (c) <b>and bones of Pelvis &amp; spine</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
18. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 14th</b> , 19 <b>59</b> , to <b>July 19th</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 14th</b> , 19 <b>59</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>110 Clay St., Annapolis, Md.</b> DATE SIGNED <b>7/19/59</b>							
ACTUAL SIGNATURE <b>R. L. Richardson</b>				PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7-23-1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Centers Methodist</b>				22d. LOCATION (City, town, or county) (State) <b>Friendship Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Keese</b>				24a. REC'D BY REGISTRAR <b>BUL 21 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7507

## CERTIFICATE OF DEATH

08647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Drury</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --				d. STREET ADDRESS --			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>Emily</b> Last <b>DRURY</b>				4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OF RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 1870</b>	
9. AGE (In years, months, days, hours, minutes) <b>89</b> yrs. <b>9</b> mos. <b>9</b> days <b>9</b> hrs. <b>9</b> min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Schoolteacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>James O. Drury, Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Mayhew</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. --				17. INFORMANT <b>Mr. James O. Drury, Jr.</b> Address <b>3110 Penna Ave S.E., Wash 20, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Arteriosclerosis, generalized, severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 6</b> , 19 <b>59</b> , to <b>July 9</b> , 19 <b>59</b> ; that I last saw the deceased alive on <b>July 6</b> , 19 <b>59</b> , and that death occurred at <b>12:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Upper Marlboro, Maryland</b> DATE SIGNED <b>7/9/59</b>							
ACTUAL SIGNATURE <b>R. B. Sasscer</b> M.D.				PHYSICIAN'S NAME (Type) <b>R. B. Sasscer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Klaus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF JUDGE	

PAID

THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND  
RECEIVED  
JAN 15 1907



# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

1501

1501

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		10-10-1876		NEW YORK, N.Y.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
100 W. 10th St., New York, N.Y.		Clerk		Heart Disease		Natural		10-10-1921		New York, N.Y.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARRIAGE		SIGNED BY	
JAMES J. JONES		JANE J. JONES		High School		Roman Catholic		Married		Physician	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
10-10-1921		New York, N.Y.		Heart Disease		Natural		10-10-1921		New York, N.Y.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARRIAGE		SIGNED BY	
JAMES J. JONES		JANE J. JONES		High School		Roman Catholic		Married		Physician	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7509

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Saltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>7 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Arunde Beach</u>				d. STREET ADDRESS <u>220 E. 25th, st.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. S. Elizabeth Fisher</u>				4. DATE OF DEATH Month Day Year <u>July 12th. 19 59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/16/05</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Arthur C. Adams</u>				14. MOTHER'S MAIDEN NAME <u>Helen Bueschel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. John L. Fisher (Husband)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/12/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. York</u>				ADDRESS <u>2224 N. Charles</u>		24a. REC'D BY REGISTRAR <u>JUL 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

1. Name of Deceased		2. Sex		3. Age		4. Race		5. Date of Death		6. Time of Death		7. Place of Death		8. Cause of Death		9. Manner of Death		10. Signature of Medical Examiner		11. Signature of Coroner		12. Signature of Registrar	
John Doe		Male		35		White		Jan 1, 1950		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of Informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Hospital		21. Physician		22. Signature of Informant		23. Signature of Physician		24. Signature of Registrar	
Jane Doe		Wife		123 Main St		New York		NY		10001		123-4567		St. John's		Dr. Smith		[Signature]		[Signature]		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

7510

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07475

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY <i>AA.</i> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <i>Ind.</i> b. COUNTY <i>AA.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PASADENA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PASADENA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Old Annap. Rd.</i>		d. STREET ADDRESS <i>Old Annap. Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>WILLIAM</i> Middle <i>H.</i> Last <i>FORD.</i>		<b>4. DATE OF DEATH</b> Month <i>JULY</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-10-83</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>C.S. Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Clark</i>		14. MOTHER'S MAIDEN NAME <i>Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Family - Jane</i>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO (c) <i>GENERALIZED ARTERIOSCLEROSIS</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>48 HOURS</i> <i>2 YRS.</i> <i>5 YRS.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CEREBRAL ARTERIOSCLEROSIS</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JULY 25</i> , 1959, to <i>JULY 29</i> , 1959, that I last saw the deceased alive on <i>JULY 29</i> , 1959, and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur Lankford Jr.</i>		ADDRESS (Street, city or town, state) <i>Mountain Rd.</i>	
DATE SIGNED <i>7-30-59</i>			
PHYSICIAN'S NAME (Type) <i>ARTHUR LANKFORD JR.</i>		<i>Pasadena Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>8-3-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>For Henry Funeral Home</i>		ADDRESS <i>130 E. To L. Cir.</i>	
24a. REC'D BY REGISTRAR DATE <i>AUG 4 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

05152

MAYLAND STATE DEPARTMENT OF HEALTH - BATHING, 18

## CERTIFICATE OF DEATH

7510

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF WITNESS [Faint text]	
17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF WITNESS [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF WITNESS [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF WITNESS [Faint text]	
23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF WITNESS [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF WITNESS [Faint text]	
27. SIGNATURE OF DECEASED [Faint text]		28. SIGNATURE OF WITNESS [Faint text]	
29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF WITNESS [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF WITNESS [Faint text]	
33. SIGNATURE OF DECEASED [Faint text]		34. SIGNATURE OF WITNESS [Faint text]	
35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF WITNESS [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF WITNESS [Faint text]	
39. SIGNATURE OF DECEASED [Faint text]		40. SIGNATURE OF WITNESS [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF WITNESS [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF WITNESS [Faint text]	
45. SIGNATURE OF DECEASED [Faint text]		46. SIGNATURE OF WITNESS [Faint text]	
47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF WITNESS [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF WITNESS [Faint text]	
51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF WITNESS [Faint text]	
53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF WITNESS [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF WITNESS [Faint text]	
57. SIGNATURE OF DECEASED [Faint text]		58. SIGNATURE OF WITNESS [Faint text]	
59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF WITNESS [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF WITNESS [Faint text]	
63. SIGNATURE OF DECEASED [Faint text]		64. SIGNATURE OF WITNESS [Faint text]	
65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF WITNESS [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF WITNESS [Faint text]	
69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF WITNESS [Faint text]	
71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF WITNESS [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF WITNESS [Faint text]	
75. SIGNATURE OF DECEASED [Faint text]		76. SIGNATURE OF WITNESS [Faint text]	
77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF WITNESS [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF WITNESS [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF WITNESS [Faint text]	
83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF WITNESS [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF WITNESS [Faint text]	
87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF WITNESS [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF WITNESS [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF WITNESS [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF WITNESS [Faint text]	
95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF WITNESS [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF WITNESS [Faint text]	
99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF WITNESS [Faint text]	

1

RECEIVED  
MAY 19 1954  
MAYLAND STATE DEPARTMENT OF HEALTH - BATHING, 18

TO HOSPITAL CO. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7477

## CERTIFICATE OF DEATH

Reg. Dist. No. 07476

1. PLACE OF DEATH o. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11 Severn Ave</i>		d. STREET ADDRESS <i>11 Severn Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Bertha</i> Middle <i>Bright</i> Last <i>Francis</i>		4. DATE OF DEATH Month <i>July</i> Day <i>16<sup>th</sup></i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar-29-1890</i>
9. AGE (In years lost birthday) yrs. <i>69</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Bright</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Custer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Miss Sue Carraway</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> to <i>1959</i> , that I last saw the deceased alive on <i>1958</i> , and that death occurred at <i>11, from the causes and on the date stated above.</i> ADDRESS (street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>E. H. [Signature]</i>		M.D. <i>[Signature]</i>	
PHYSICIAN'S NAME (Type) <i>E. H. [Signature]</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 18-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Ann's Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 20 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kross</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Item 20 FilmG244 7-13-59 ans					Item 7 FilmG244 7/13/59 cap					
7511					07477					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY		Anne Arundel			a. STATE		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Pasadena			b. COUNTY		A. A.			
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		XXXXXXX Pasadena			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Earleigh Hgts. Rd. S. of Ritchie Hwy.					Hamburg and Light Streets					
3. NAME OF DECEASED (Type or Print)					4. DATE OF DEATH		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First		Middle		Last		Month		Day		
ALBERT		MARION		FRIEND		July		1		
Year								19 59		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		May 14, 1889		70 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Painter						South Carolina		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Robert Friend					Julia Hampton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT Address			
no					none		Mrs Marian Snoberger, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination due to severed femoral artery</u>										
812X DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
Pedestrian struck by auto										
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (State)	
Month, Day, Year			While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Street		Pasadena		A.A. Md.	
Hour a. m. p. m.			19							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Charles S. Petty</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Charles S. Petty, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED 7/1/59										
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
BURIAL			7/3/59		Glen Haven		Glen Burnie, Md			
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Hoppling & Kirkland					Glen Burnie		DATE JUL 6 '59		Carlton L. Hunt	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

So 6-2200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 19&20 Film 246 8-12-59 ams

07478

# CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ft George G. Meade</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		d. STREET ADDRESS <b>NSA</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JERRY</b> Middle <b>L.</b> Last <b>GARMON</b>		4. DATE OF DEATH Month <b>15</b> Day <b>July</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Oct 1936</b>
9. AGE (In years last birthday) yrs. <b>22</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Donald Laverne Garmon</b>		14. MOTHER'S MAIDEN NAME <b>Marion Rachiel (last name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>entered 4 Feb 54</b>		16. SOCIAL SECURITY NO. <b>490-44-9944</b>	
17. INFORMANT <b>Military Records NSA, Ft Meade, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gunshot Wounds of Abdomen</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Gunshot -- Homicide</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. <b>0245</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Waterloo Md Parked Waterloo</b>		20f. (City or town) (County) (State) <b>Anne Arundel Md</b>	
21. I certify that I attended the deceased from <b>15 July</b> , 19 <b>59</b> to <b>15 July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>15 July</b> , 19 <b>59</b> , and that death occurred at <b>0645 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Howard Bob Mass, Capt. U.S. Army Hospital, Ft Meade, Md 15 Jul 59</b>			
ACTUAL SIGNATURE <b>Howard Bob Mass, Capt. U.S. Army Hospital, Ft Meade, Md 15 Jul 59</b>			
PHYSICIAN'S NAME (Type) <b>HOWARD BOB MASS, Capt, MC U.S. Army Hospital, Ft George G. Meade, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Gorin, Mo.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 20 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

# CERTIFICATE OF DEATH

For use in

1. Name of deceased  
2. Sex  
3. Race

4. Age

5. Date of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of burial

20. Signature of burial

21. Signature of burial

22. Signature of burial

23. Signature of burial

24. Signature of burial

25. Signature of burial

26. Signature of burial

27. Signature of burial

28. Signature of burial

29. Signature of burial

30. Signature of burial

31. Signature of burial

32. Signature of burial

33. Signature of burial

7513

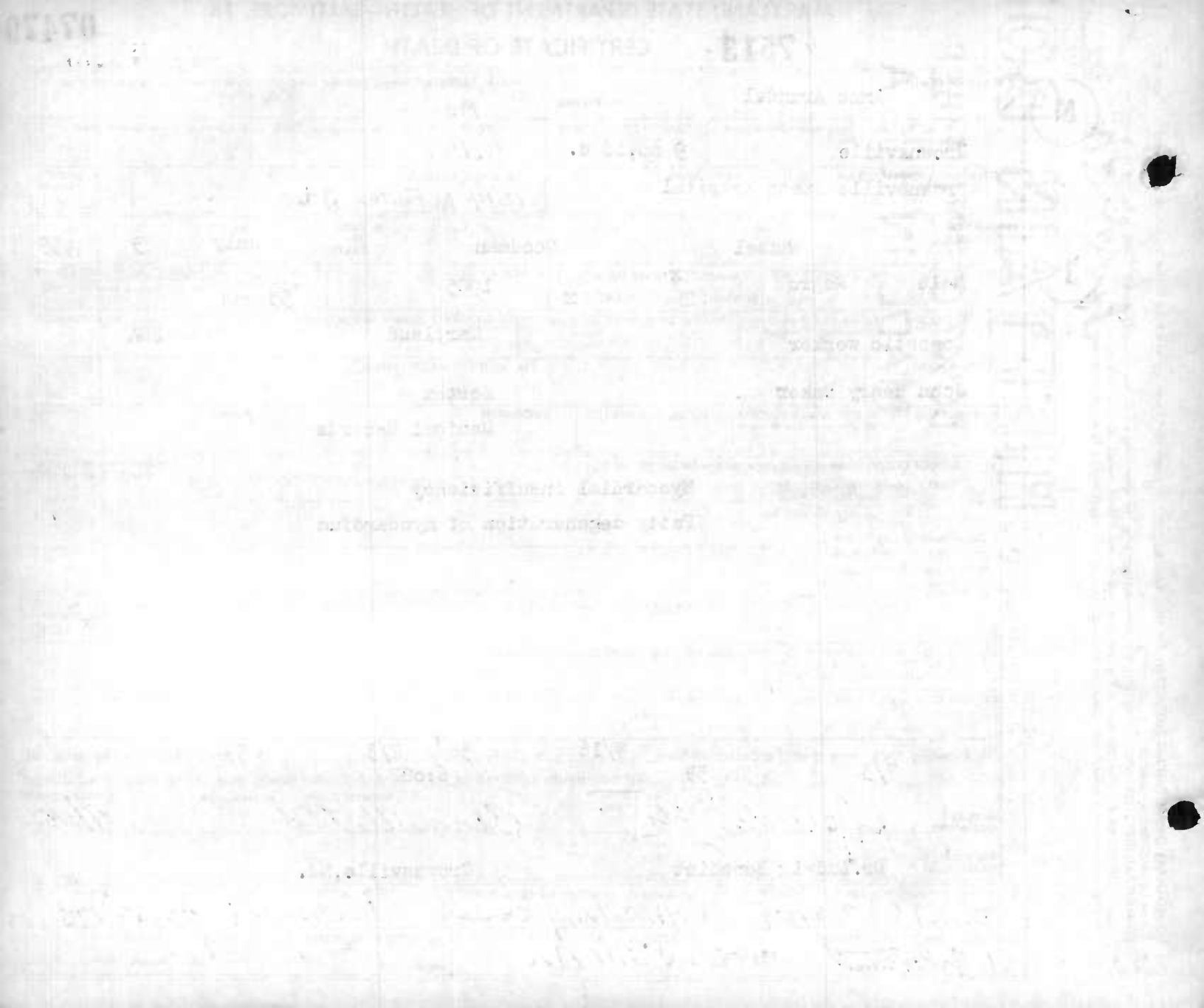
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR (If institution) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>1514 N. Fulton St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>Goodman</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1905</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Henry Baker</b>		14. MOTHER'S MAIDEN NAME <b>Bertha</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Medical Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>4222</b> DUE TO <b>Fatty degeneration of myocardium</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/16</b> , 19 <b>58</b> , to <b>7/3</b> , 19 <b>59</b> that I last saw the deceased alive on <b>7/3</b> , 19 <b>59</b> , and that death occurred at <b>6:08 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>7/5/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Ludwig Benedict</b>		<b>Crownsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Anne Arundel County MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>918 Druid Hill Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7514

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head, Md.</u> 08x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Rt. 1, Box 110</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>D.</u> Last <u>Gutrick</u>				4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-82</u>		9. AGE (In years last birthday) yrs. <u>76?</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Government Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. - -		INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive &amp; Arteriosclerotic Cardiovascular</u> DUE TO <u>Renal disease &amp; cardiomegaly.</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. - - - - 19 - - - -				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -	
20f. (City or town) - - - - -				20g. (County) - - - - -		20h. (State) - - - - -	
21. I certify that I attended the deceased from <u>5/4</u> , 19 <u>59</u> , to <u>7/30</u> , 19 <u>59</u> that I last saw the deceased alive on <u>7/30</u> , 19 <u>59</u> , and that death occurred at <u>11:25</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hosp., Md.</u> DATE SIGNED <u>7/31/59</u>							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>				M.D. <u>Crownsville State Hosp., Md.</u> <u>7/31/59</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>				<u>Crownsville State Hosp., Md.</u> <u>7/31/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-5-59 Zion Baptist</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Top, Chas. Co. Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Montgomery Bro. 913 Thacker</u>				24a. REC'D BY REGISTRAR <u>54</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7515

## CERTIFICATE OF DEATH

Reg. Dist. No.

07480

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Thomas</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>7</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/22/13</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tate Hall</b>		14. MOTHER'S MAIDEN NAME <b>Helen Roberta Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442x</b> DUE TO <b>Nephrotic Syndrome</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Hypertensive Cardiovascular Renal Disease</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/22</b> , 19 <b>57</b> , to <b>7/14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/14</b> , 19 <b>59</b> , and that death occurred at <b>6:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>7/14/59</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>7/14/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial July 18, 1959</b>		22b. DATE THEREOF <b>July 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Calvin C. Wilson</b>		24a. REC'D BY REGISTRAR <b>Jul 16 1959</b>	
ADDRESS <b>2004 Ind. Ave. Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>md</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7516 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08655

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>		c. LENGTH OF STAY IN lb <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5920 Bellegrove Rd.</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) First <u>Gertie</u> Middle <u>Hall</u> Last <u></u>				4. DATE OF DEATH Month <u>July</u> Day <u>23rd</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>75 ?</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (domestic)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. Edith Howard (same address as deceased)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General asthenia</u> (c) <u></u> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>7/23/59</u>	
22a. BURIAL (CREMATION REMOVAL (Specify))		22b. DATE THEREOF <u>8-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>W. M. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 27 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, try, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7478

## CERTIFICATE OF DEATH

Reg. Dist. No.

07481

1. PLACE OF DEATH a. COUNTY <u>Cyrene Grundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2017 Forest Drive</u>		d. STREET ADDRESS <u>2017 Forest Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hattie Hall</u>		4. DATE OF DEATH Month Day Year <u>7 10 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Joseph Jennings Anna, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1958</u> to <u>July 19, 1959</u> , that I last saw the deceased alive on <u>July 10, 1959</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robt. Richardson</u>		DATE SIGNED <u>7/13/59</u>	
PHYSICIAN'S NAME (Type) <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS <u>110-CHRYST ANNAPOIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-14-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake Memorial</u>	
22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>		22e. REC'D BY REGISTRAR <u>WILLIAM REESE, JR.</u>	
22f. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		DATE <u>JUL 14 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18430

RECEIVED

18430



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7517**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **07482**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>AA</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedarhurst, Shadyside</b> c. LENGTH OF STAY IN 1b <b>5 yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedarhurst, Shadyside, M.D.</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>MAUDE JESSE HARR</b> First Middle Last				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>6</b> Year <b>19 59</b>											
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12/28/55</b>		<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>6</b> Days <b>8</b>		<b>11. IF UNDER 24 HRS.</b> Hours <b>8</b> Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hundred W. U.</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.A.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>James M. McCullough</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH DAVIS</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, name unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>—</b>				<b>17. INFORMANT</b> <b>Lillian M. Fitzhugh, Shadyside Md.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8 Carcinoma of colon (adenocarcinoma)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>1 year +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <b>April 1, 1959</b> , to <b>July 6, 1959</b> , that I last saw the deceased alive on <b>July 4, 1959</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.															
<b>ACTUAL SIGNATURE</b> <b>Willard F. Smith</b> M.D.						<b>ADDRESS</b> (Street, city or town, state) <b>Shadyside, Md.</b>						<b>DATE SIGNED</b> <b>7/6/59</b>			
<b>PHYSICIAN'S NAME</b> (Type) <b>WILLARD F. SMITH, MD</b>															
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Buried</b>				<b>22b. DATE THEREOF</b> <b>7/10/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>WOODMOUNT</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>FAIRMOUNT W. U.</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Bernard A. Dwyer</b>						<b>ADDRESS</b>						<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>	
<b>DATE</b> <b>JUL 14 '59</b>															

TO HOSPITAL (If attending physician): The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



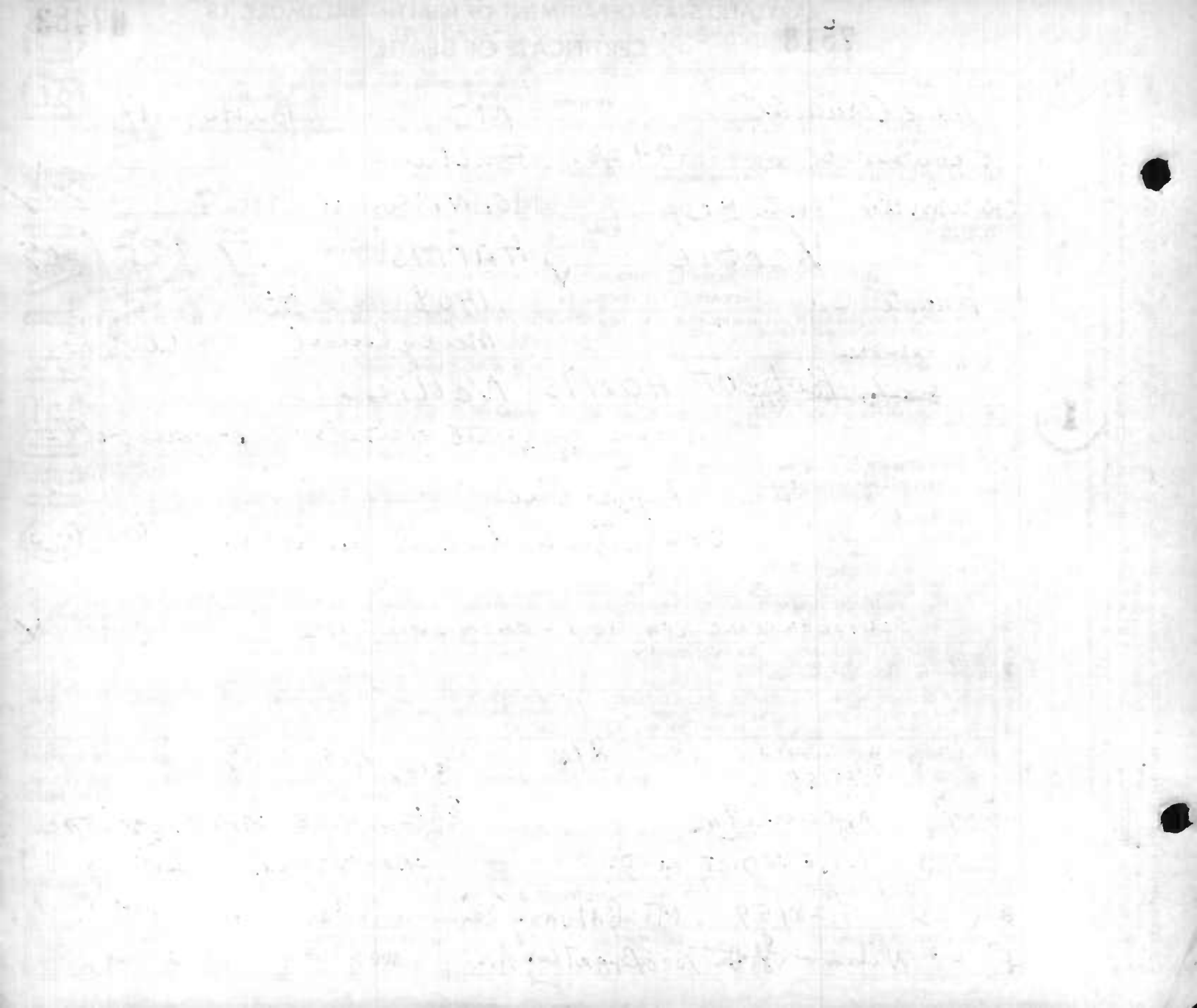
7518 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 8,9 FilmG246 8-14-59 et  
CERTIFICATE OF DEATH

07483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Balto-city</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>21 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hosp.</i>		d. STREET ADDRESS <i>101 N. Bond Street.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Hertie Harris</i>		4. DATE OF DEATH Month Day Year <i>7 125 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <i>35</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Harris</i>		14. MOTHER'S MAIDEN NAME <i>Nellie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Hospital records</i>		Address <i>Crownsville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypoxia</i> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>congestive heart failure.</i> DUE TO (c) <i>1000 1000</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>PSYCHOPHRENIC REACTION - CATATONIC TYPE</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/6</i> , 19 <i>35</i> , to <i>7/25</i> , 19 <i>59</i> that I last saw the deceased alive on <i>7/25/59</i> , 19 <i>59</i> , and that death occurred at <i>3:40</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>L. Benedict M.D.</i>		ADDRESS (Street, city or town, state) <i>CROWNVILLE STATE HOSPITAL</i>	
PHYSICIAN'S NAME (Type) <i>L. BENEDICT M.D.</i>		DATE SIGNED <i>CROWNVILLE, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/28/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. CATHARY Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Cedar Hill, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. O. Wilson</i>		ADDRESS <i>1000 Brantley Ave.</i>	
24a. REC'D BY REGISTRAR DATE <i>AUG 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton &amp; Thana</i>	

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fair Haven</u>		c. LENGTH OF STAY IN 1b <u>3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Herbert</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1942</u>
9. AGE (in years last birthday) <u>17</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chorister</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Franklin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>5-10-100000</u>	
17. INFORMANT <u>Josephine Mackell</u>		Address <u>Navy Yard, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO <u>rowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart</u> DUE TO (c) <u>Heart</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Heart</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart</u>		20c. TIME OF INJURY Month, Day, Year <u>7/30/59</u> Hour <u>11</u> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>	
20f. (City or town) <u>Fair Haven</u>		20g. (County) <u>Anne Arundel</u>	
20h. (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>E. H. Abbott</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. H. Abbott</u>		DATE SIGNED <u>7/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>8-1-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>	22d. LOCATION (City, town, or county) (State) <u>Brewery, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		24. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>	
ADDRESS <u>William Reese, Jr. - Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is required, the certificate should be executed within 72 hours after death. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





7479

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wesley</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 30, 1907</b>	9. AGE (In years lost birthday) yrs. <b>51</b>	IF UNDER 1 YEAR Months <b>51</b> Days <b>51</b> Hours <b>51</b> Min. <b>51</b>	IF UNDER 24 HRS. Months <b>51</b> Days <b>51</b> Hours <b>51</b> Min. <b>51</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maintenence</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>St. Rd. Comm.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Isiah Jones</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-16-5914</b>			
17. INFORMANT <b>Frene Brown Davidsonville, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebellar and Pontine Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vascular disease</b> DUE TO (c) <b>10 days</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left lower lobe pneumonia</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month <b>July</b> Day <b>20</b> Year <b>1959</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 11, 1959</b> , to <b>July 20, 1959</b> , that I lost saw the deceased olive on <b>July 20, 1959</b> , and that death occurred at <b>3:42A.M.</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>110 Clay St.,</b> DATE SIGNED <b>7/21/59</b>			
ACTUAL SIGNATURE <b>R. L. Richardson</b>				M.D. <b>110 Clay St.,</b>			
PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chews Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Chewsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. Annapolis, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>JUL 22 59</b>	
				DATE		24b. REGISTRAR'S SIGNATURE <b>Ernest B. Hanes</b>	

03987

CERTIFICATE OF DEATH

DATE

Name of deceased

Age

Sex

Color

Place of birth

Married

Single

Widow

Divorced

Other

Place of death

Time

Day

Month

Year

Signature of physician

Signature of registrar

Signature of informant

Signature of witness

Signature of undertaker

Signature of funeral home

Signature of cemetery

Signature of church

Signature of family

Signature of friends

7520

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVA</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIVA GUEST HOUSE</b>				d. STREET ADDRESS <b>1131 Tyler Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>I</b> Last <b>KNADLER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1885</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>N Y C</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Phillip Phelps</b>				14. MOTHER'S MAIDEN NAME <b>Rgina ( unknown )</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs Wilbur H. McNew Sr. - Daughter</b>		Address <b>742 Warren Dr Annapolis, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> DUE TO <b>Cema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple cerebrovascular thromboses</b> DUE TO (c) <b>Multiple cerebrovascular thromboses</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>332x</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 day</b> <b>7 yr</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July</b> , 19 <b>55</b> , to <b>July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 23</b> , 19 <b>59</b> , and that death occurred at <b>1:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John L Hedeman</b>				M.D. <b>121 Cathedral</b>		DATE SIGNED <b>7/27/59</b>	
PHYSICIAN'S NAME (Type) <b>John Hedeman</b>				<b>Annapolis Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 29, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 29 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carles E. Farnell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

03450

CERTIFICATE OF DEATH

03450

Full Name

Married Name

Age

Sex

XX

Date of Birth

Place of Birth

1

2

3

4

5

6

7

8

9

10

11

County of ... State of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07487

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> <u>0354 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8483 Ft. Smallwood Rd.</u>		d. STREET ADDRESS <u>23 Terrace Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>J</u> Middle <u>KRALL</u> Last		4. DATE OF DEATH <u>JULY</u> Month <u>9</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Catherine McCullough Krall, wife, above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>UNKALOWN</u> <u>2 YRS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9 30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Arthur Lankford Jr</u> M.D. <u>Mountain Rd</u> PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR MD</u> <u>Pasadena Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> ADDRESS <u>Funeral Home 3331 Brahms Lane</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
7523 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>a.a.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Pt. Pleasant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jct. Staterts. 177 and 648</u>				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>T</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Isaac Martin</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Philip Rosenberg, 610 Washington Blvd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple traumatic injuries</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto while walking.</u>					
20c. TIME OF INJURY Hour <u>2:25</u> a. m. <u>xxxx</u> Month <u>July</u> Day <u>4</u> Year <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Pasadena Anne Arundel Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles S. Petty</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles S. Petty</u>				DATE SIGNED <u>7/4/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlbert S. Kraus</u>	



7522

## CERTIFICATE OF DEATH

07489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater Md</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Katherine Beach McBride</i>		4. DATE OF DEATH <i>July 31, 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 19, 1900</i>
9. AGE (In years last birthday) <i>59 yrs</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary U.S. Government</i>	
11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles B. Mather</i>		14. MOTHER'S MAIDEN NAME <i>Maudie Stephens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Antia M Smith, Edgewater Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized carcinomatosis</i> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Primary to cancer of left breast</i> DUE TO (c) <i>4 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 5, 1959</i> , to <i>July 31, 1959</i> , that I last saw the deceased alive on <i>July 31, 1959</i> , and that death occurred at <i>11:00</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sylvia M. Linn</i> M.D.		ADDRESS (Street, city or town, state) <i>RFD #1 Box 277-M Edgewater, Md.</i>	
DATE SIGNED <i>7/31/59</i>			
PHYSICIAN'S NAME (Type) <i>Sylvia M. Linn</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug 3, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gaschs Sons</i> ADDRESS <i>Hyattsville Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 3 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

\$525

7524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ma</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edgewater P.O.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>Lacey</u> Middle <u>McCarter</u> Last				4. DATE OF DEATH <u>JULY</u> Month <u>6</u> Day <u>1959</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-1881</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>aa Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Francis Stullings</u>				14. MOTHER'S MAIDEN NAME <u>Emma Harriett Wheeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>James E. McCarter</u> Address <u>143 Spa Viewline Annapolis Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic hypertensive -</u> DUE TO <u>Cardiovascular disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>7 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 27, 1959</u> to <u>July 3, 1959</u> , that I last saw the deceased alive on <u>July 3, 1959</u> , and that death occurred at <u>5:07 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Edgewater, Md.</u> DATE SIGNED <u>7/6/59</u>							
ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D.				RFD #1 Box 272-M			
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u>				<u>Edgewater, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-8-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>MAYO NEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MAYO MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SONS ANNAPOLIS MD</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUL 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. H.</u>	





7480

CERTIFICATE OF DEATH

07491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>H</u> Last <u>MORGAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 21<sup>st</sup> 1873</u>	
9. AGE (In years last birthday) <u>85</u>		10. IF UNDER 1 YEAR Months <u>18</u> Days <u>05</u>		11. IF UNDER 24 HRS. Hours <u>00</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assoc Salesman Ret</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>		11. BIRTHPLACE (State or foreign country) <u>Winsted Conn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James P. Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Informant</u>			
17. ADDRESS <u>Mrs John Jacobson</u>				18. ADDRESS <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 23, 1959</u> , to <u>July 27, 1959</u> , that I last saw the deceased alive on <u>July 27, 1959</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St., Annapolis, Md.</u> DATE SIGNED <u>7/28/59</u>							
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Richard N. Peeler</u> <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 30-59</u>		<u>London Park Cem</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

01431

CERTIFICATE OF DEATH

1980

H

DATE OF DEATH: 10-10-80  
PLACE OF DEATH: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
MARRIAGE: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
RELIGION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]

1. Name of deceased: [illegible]  
2. Date of birth: [illegible]  
3. Place of birth: [illegible]  
4. Sex: [illegible]  
5. Race: [illegible]  
6. Marital status: [illegible]  
7. Occupation: [illegible]  
8. Education: [illegible]  
9. Religion: [illegible]  
10. Cause of death: [illegible]  
11. Manner of death: [illegible]

I

12. Signature of physician: [illegible]  
13. Date of death: [illegible]  
14. Place of death: [illegible]  
15. Age: [illegible]  
16. Sex: [illegible]  
17. Race: [illegible]  
18. Marital status: [illegible]  
19. Occupation: [illegible]  
20. Education: [illegible]  
21. Religion: [illegible]  
22. Cause of death: [illegible]  
23. Manner of death: [illegible]

24. Signature of physician: [illegible]  
25. Date of death: [illegible]  
26. Place of death: [illegible]  
27. Age: [illegible]  
28. Sex: [illegible]  
29. Race: [illegible]  
30. Marital status: [illegible]  
31. Occupation: [illegible]  
32. Education: [illegible]  
33. Religion: [illegible]  
34. Cause of death: [illegible]  
35. Manner of death: [illegible]

36. Signature of physician: [illegible]  
37. Date of death: [illegible]  
38. Place of death: [illegible]  
39. Age: [illegible]  
40. Sex: [illegible]  
41. Race: [illegible]  
42. Marital status: [illegible]  
43. Occupation: [illegible]  
44. Education: [illegible]  
45. Religion: [illegible]  
46. Cause of death: [illegible]  
47. Manner of death: [illegible]

48. Signature of physician: [illegible]  
49. Date of death: [illegible]  
50. Place of death: [illegible]  
51. Age: [illegible]  
52. Sex: [illegible]  
53. Race: [illegible]  
54. Marital status: [illegible]  
55. Occupation: [illegible]  
56. Education: [illegible]  
57. Religion: [illegible]  
58. Cause of death: [illegible]  
59. Manner of death: [illegible]

Item 18 Film 245 7-20-59 and 7481

7481

063

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

063

1

2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial infarction due to Coronary

420.0 DUE TO Thrombosis due to Arteriosclerotic Heart

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Disease

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While of work ☐ Not while of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED 7/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7-19-1959 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Chapel 22d. LOCATION (City, town, or county) (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Wm. Keese ADDRESS 108 N. 1st St. Annapolis, Md. 24a. REC'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Keene



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>14</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA ANNE Arundel General</u>		d. STREET ADDRESS <u>2416 Pelham AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>Hubert</u> Middle <u>Nicholson</u> Last <u>Nicholson</u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 18 1921</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transit Co - Balto</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Mills Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Vinton Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Sadie White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>14-76-5835</u>	
17. INFORMANT Name <u>Bernadine M. Nicholson</u> Address <u>6304 ALE AVE BALTO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Struck by Lightning.</u> 935.8 DUE TO <u>BURNS OF SCALP - ANTERIOR - CHEST -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Lower extremities - bilateral</u> (b) <u>Sudden</u> (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (For nature of injury in Part I or Part II of item 18.) <u>Struck by lightning</u>	
20c. TIME OF INJURY Month <u>7</u> Day <u>24</u> Year <u>1959</u> Hour <u>7</u> a.m. <u>7</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Town</u>		20f. (City or town) <u>AA Co.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. White</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. White</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>28 JULY 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Miller</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>	
ADDRESS <u>10110 B. Miller</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58

7483  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 07494

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 Murray Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE W NUTWELL</b>		4. DATE OF DEATH Month Day Year <b>JULY 28 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Water Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Issac S. Nutwell</b>		14. MOTHER'S MAIDEN NAME <b>Roberta Winterson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>219-30-3591</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		18. INTERVAL BETWEEN ONSET AND DEATH <b>Chronic heart failure</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/28/59</b> to <b>7/28/59</b> , that I last saw the deceased alive on <b>7/28/59</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Annapolis, Maryland</b>	
ACTUAL SIGNATURE <b>Elmer G. Linhardt MD</b>		DATE SIGNED <b>July 30, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Elmer G. Linhardt MD</b>		<b>Annapolis, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 31, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lothian, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

07/10

CERTIFICATE OF DEATH

1983

1. Name of Deceased: [illegible]  
2. Date of Birth: [illegible]  
3. Date of Death: [illegible]  
4. Place of Birth: [illegible]  
5. Place of Death: [illegible]  
6. Cause of Death: [illegible]  
7. Signature of Registrar: [illegible]  
8. Signature of Medical Officer: [illegible]  
9. Signature of Coroner: [illegible]

10. Name of Informant: [illegible]  
11. Address of Informant: [illegible]  
12. Signature of Informant: [illegible]  
13. Date of Registration: [illegible]  
14. Registrar's Office: [illegible]

15. Name of Deceased: [illegible]  
16. Date of Birth: [illegible]  
17. Date of Death: [illegible]  
18. Place of Birth: [illegible]  
19. Place of Death: [illegible]  
20. Cause of Death: [illegible]  
21. Signature of Registrar: [illegible]  
22. Signature of Medical Officer: [illegible]  
23. Signature of Coroner: [illegible]

24. Name of Informant: [illegible]  
25. Address of Informant: [illegible]  
26. Signature of Informant: [illegible]  
27. Date of Registration: [illegible]  
28. Registrar's Office: [illegible]

7484

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arudel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sadie</b> Middle <b>O'HARA</b> Last <b>O'HARA</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 7, 1885</b>		9. AGE (In years lost birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b>	IF UNDER 24 HRS. Hours <b>73</b> Min. <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dietician</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Henry Edgell</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Heather</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>1</b>		16. SOCIAL SECURITY NO. <b>157X</b>		INFORMANT Address <b>Amos Garrett Blvd., 7/8/59</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>157X</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 24, 19 59</b> , to <b>July 8, 19 59</b> , that I last saw the deceased alive on <b>July 8, 19 59</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Amos Garrett Blvd.,</b> DATE SIGNED <b>7/8/59</b>							
ACTUAL SIGNATURE <b>S. Borssuck</b>		M.D. <b>Amos Garrett Blvd.,</b>					
PHYSICIAN'S NAME (Type) <b>Samuel Borssuck</b>		<b>Annapolis, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 10 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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EXHIBIT OF

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7525

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>42yr. 8mo. 3da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10. ANNAPOLIS	
3. NAME OF DECEASED (Type or print) First <b>Josephine</b> Middle <b>Olney</b> Last <b>Olney</b>				4. DATE OF DEATH Month <b>7</b> Day <b>27</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1893?</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Ridgley</b>				14. MOTHER'S MAIDEN NAME <b>Susan West</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>- - -</b>			
17. INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> DUE TO <b>Subarachnoid Hemorrhage</b> (b) <b>Hypertensive Cardiovascular Disease associated with Generalized Arteriosclerosis</b> DUE TO (c) <b>- - -</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>- - -</b>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>- - -</b>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>- - -</b>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>- - - 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>- - -</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>11/24</b> , 19 <b>16</b> , to <b>7/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/27</b> , 19 <b>59</b> , and that death occurred at <b>5:30 A.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M.D.</b>				ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b>				DATE SIGNED <b>5/27/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hope Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Edgewater, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. Annapolis, Md.</b>				24a. REC'D BY REGISTRAR <b>29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

1882

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7485

CERTIFICATE OF DEATH

Reg. Dist. No.

07497

<b>1. PLACE OF DEATH</b> a. COUNTY <i>a a</i> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>1 hr</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X West River</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hospital</i>				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <i>Agnes MARION O'NEILL</i>				<b>4. DATE OF DEATH</b> Month Day Year <i>July 3 1959</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 28 1872</i>			
9. AGE (In years last birthday) yrs. <i>87</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>West River, MD.</i>		11. BIRTHPLACE (State or foreign country) <i>West River, MD.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>West River, MD.</i>									
13. FATHER'S NAME <i>Phillip Mayhew</i>				14. MOTHER'S MAIDEN NAME <i>Catherine JENKINS</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Joseph H. O'NEILL, West River, MD.</i>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO (c) <i>myocardial infarction</i>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>cert.</i> 19 <i>56</i> , to <i>July 3</i> , 19 <i>59</i> ; that I last saw the deceased alive on <i>July 2</i> , 19 <i>59</i> , and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D.				ADDRESS (Street, city or town, state) <i>Sethwood, Md.</i> DATE SIGNED <i>7-6-59</i>					
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/6/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Our Lady of Sorrows</i>		22d. LOCATION (City, town, or county) (State) <i>West River MD</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Herold</i>				ADDRESS <i>Sethwood, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 13 '59</i>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>					



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7526

CERTIFICATE OF DEATH

Reg. Dist. No.

07498

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burton</b> <b>Glenelg</b> <b>13x-2</b>	
f. STREET ADDRESS <b>1401 Maryland Ave</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Gertrude</b> Last <b>Penn</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 June 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13. FATHER'S NAME <b>Jefferson Jackson Brown</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Alice Massey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Brother:</b>		Address <b>S.J. Brown 107 Gilmore St, Baltimore, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Angiosarcoma, Metastatic</b> <b>197.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>13 July</b> , 19 <b>59</b> to <b>14 July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>14 July</b> , 19 <b>59</b> , and that death occurred at <b>02:55A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Army Hospital, Ft Meade, Md</b> DATE SIGNED <b>14 Jul 59</b>			
ACTUAL SIGNATURE <b>Leon E. Kassel</b> M.D.		U.S. Army Hospital, Ft Meade, Md	
PHYSICIAN'S NAME (Type) <b>LEON E. KASSEL, MD,</b>		U.S. Army Hospital, Ft Meade, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-17-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H. H.</b>	

# CERTIFICATE OF DEATH

1950

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

03100

1. NAME OF DECEASED James Alexander		2. SEX Male		3. AGE 77		4. DATE OF BIRTH 1873		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH 1950		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF DECEASED [Signature]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MARYLAND. IT IS NOT VALID FOR THE PURPOSES OF THE DISTRICT OF COLUMBIA. IT IS NOT VALID FOR THE PURPOSES OF THE UNITED STATES OF AMERICA.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7486**  
**CERTIFICATE OF DEATH**

**07499**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN TB <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Rt-2, Box-592</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Herbert</b> Middle <b>L</b> Last <b>PORTER</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 31, 1910</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>48</b> Days <b>48</b>		IF UNDER 24 HRS. Hours <b>48</b> Min. <b>48</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Walter Porter</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Keppin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-22-0514</b>		INFORMANT Address <b>Frances Porter St. Margaret Md</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage due to</b> <b>443x</b> DUE TO <b>Hypertensive Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 year</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10100 Rg</b>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/12/59</b> to <b>7/12/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/12/59</b> , 19 <b>59</b> , and that death occurred at <b>10:10 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. H. Burwarden</b>				ADDRESS (Street, city or town, state) <b>110 - E. 1st St. Annapolis, Md</b>			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-16-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Arnold Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Keese</b>				ADDRESS <b>108 N. 2nd St. Annapolis, Md</b>		24a. REC'D BY REGISTRAR <b>14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Clifton S. Frank</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7527

CERTIFICATE OF DEATH

07500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sadie</b> Middle <b>Pratt</b> Last <b>Pratt</b>		4. DATE OF DEATH Month <b>7</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1896?</b>
9. AGE (In years last birthday) <b>63?</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Bronchopneumonia + Uremia</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Nephrosis</b> DUE TO (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/19</b> <b>1956</b> to <b>7/14</b> <b>1959</b> , that I last saw the deceased alive on <b>7/14</b> <b>1959</b> , and that death occurred at <b>7:45 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. Benedict, M. D.</b>		DATE SIGNED <b>7/15/59</b>	
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>7-21-59</b>		22b. DATE THEREOF <b>7-21-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. ERNEST JARVIS</b>		ADDRESS <b>1432 40th ST. N.W.</b>	
24a. REC'D BY REGISTRAR <b>JUL 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

0-00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7528

CERTIFICATE OF DEATH

07501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Cedar Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6124 Gov Ritchie Highway</u>			d. STREET ADDRESS <u>6124 Gov Ritchie Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET</u> <u>Reynolds</u>			4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26</u>		9. AGE (In years last birthday) <u>33</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Martin Anderson</u>		
14. MOTHER'S MAIDEN NAME <u>Larsen</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>			17. INFORMANT <u>Walter Reynolds</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breasts &amp; Metastases</u> DUE TO (c) <u>Heart Exhaustion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Several Days</u> <u>Unknown</u> <u>One Day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>59</u> , to <u>July 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>59</u> , and that death occurred at <u>12 A.</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Richard H. Hunt</u> M.D.			DATE SIGNED <u>July 2, 1959</u>		
PHYSICIAN'S NAME (Type) <u>RICHARD H. HUNT</u>			ADDRESS (Street, city or town, state) <u>100 Cherry Lane Glen Burnie</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Calvary</u>	
22d. LOCATION (City, town, or county) <u>Brooklyn Cedar Hill</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. A. Wilson</u>			ADDRESS <u>1000</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 10 '59</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7529 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

07502

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> <b>OLEY F. RINGLER</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		c. LENGTH OF STAY IN 1b <b>50</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		d. STREET ADDRESS <b>219 Meadow Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>219 Meadow Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLEY</b> Middle <b>F.</b> Last <b>RINGLER</b>		4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/29/92</b>
9. AGE (In years last birthday) yrs. <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USCG</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Guy Ringler</b>		14. MOTHER'S MAIDEN NAME <b>Marian Spencer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> If yes, give war or dates of service <b>-</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myeloid leukemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 April</b> , 19 <b>57</b> to <b>3 July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2 July 59</b> , 19 <b>59</b> , and that death occurred at <b>7 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Andrew R. Sosnowski</b> M.D. <b>4016 Ritchie Hwy</b> <b>6 July 59</b> BALTO - 25 - MD PHYSICIAN'S NAME (Type) <b>Andrew R. Sosnowski</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGully Funeral Homes 130 E. Fort Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Pinner</b>			

07580

CERTIFICATE OF DEATH

1938

DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		RE-MARRIED		RE-MARRIED		RE-MARRIED	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CITY		STATE	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
OCCUPATION		EDUCATION		RELIGION		RACE		ETHNICITY		COMPLEXION		HAIR		EYES	
WEIGHT		HEIGHT		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		DIGESTION		EXCRETION	
MORPHOLOGY		PHYSIOLOGY		PSYCHOLOGY		SOCIAL ADAPTATION		CULTURAL ADAPTATION		LIFE HISTORY		DEATH HISTORY		BURIAL HISTORY	
SIGNATURE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
WITNESSES		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
REGISTRATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
OFFICIAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
FAMILY		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
FRIENDS		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
CLERGY		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MEDICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LABORATORY		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
HISTORICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
GEOGRAPHICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
CLIMATOLOGICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
ASTRONOMICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
METEOROLOGICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
HYDROLOGICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
ZOOLOGICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
BOTANICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
GEOLOGICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MINERALOGICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
METALLURGICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
CHEMICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
PHYSICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MATHEMATICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATISTICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
ECONOMICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
POLITICAL		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LITERARY		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
ARTS		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
SCIENCE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
TECHNOLOGY		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NAVY		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
AIR FORCE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
ARMY		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MARINE CORPS		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
COAST GUARD		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
FISH AND WILDLIFE SERVICE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL GUARD		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE GUARD		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL GUARD		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY RESERVE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL RESERVE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE RESERVE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL RESERVE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY TRAINING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL TRAINING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE TRAINING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL TRAINING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY SERVICE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL SERVICE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE SERVICE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL SERVICE		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY EMPLOYMENT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL EMPLOYMENT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE EMPLOYMENT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL EMPLOYMENT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY EDUCATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL EDUCATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE EDUCATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL EDUCATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY RESEARCH		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL RESEARCH		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE RESEARCH		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL RESEARCH		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY DEVELOPMENT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL DEVELOPMENT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE DEVELOPMENT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL DEVELOPMENT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY INNOVATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL INNOVATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE INNOVATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL INNOVATION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REFORM		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REFORM		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REFORM		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REFORM		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REVOLUTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REVOLUTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REVOLUTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REVOLUTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL UPRISING		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL REBELLION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
NATIONAL INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
STATE INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
LOCAL INSURRECTION		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	
MILITARY REVOLT		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07503

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Schulte Ford Dealer, N. Ritchie Highway</u>				d. STREET ADDRESS <u>Route 175</u>			
3. NAME OF DECEASED (Type or print) <u>Homer Lee Ritz</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24th.</u> Year <u>19 59</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/31/14</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook and baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canton, Ohio</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roy Ritz</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Gump</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>11 World War (Army)</u>		16. SOCIAL SECURITY NO. <u>574-61-7894</u>		17. INFORMANT <u>Mr. Robert W. Kramer, 8 W. Barney St. Baltimore.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/24/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, 6009 Harford Road, ZONE 14</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Kramer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. File pages 3 and 4 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. File pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



7531

## CERTIFICATE OF DEATH

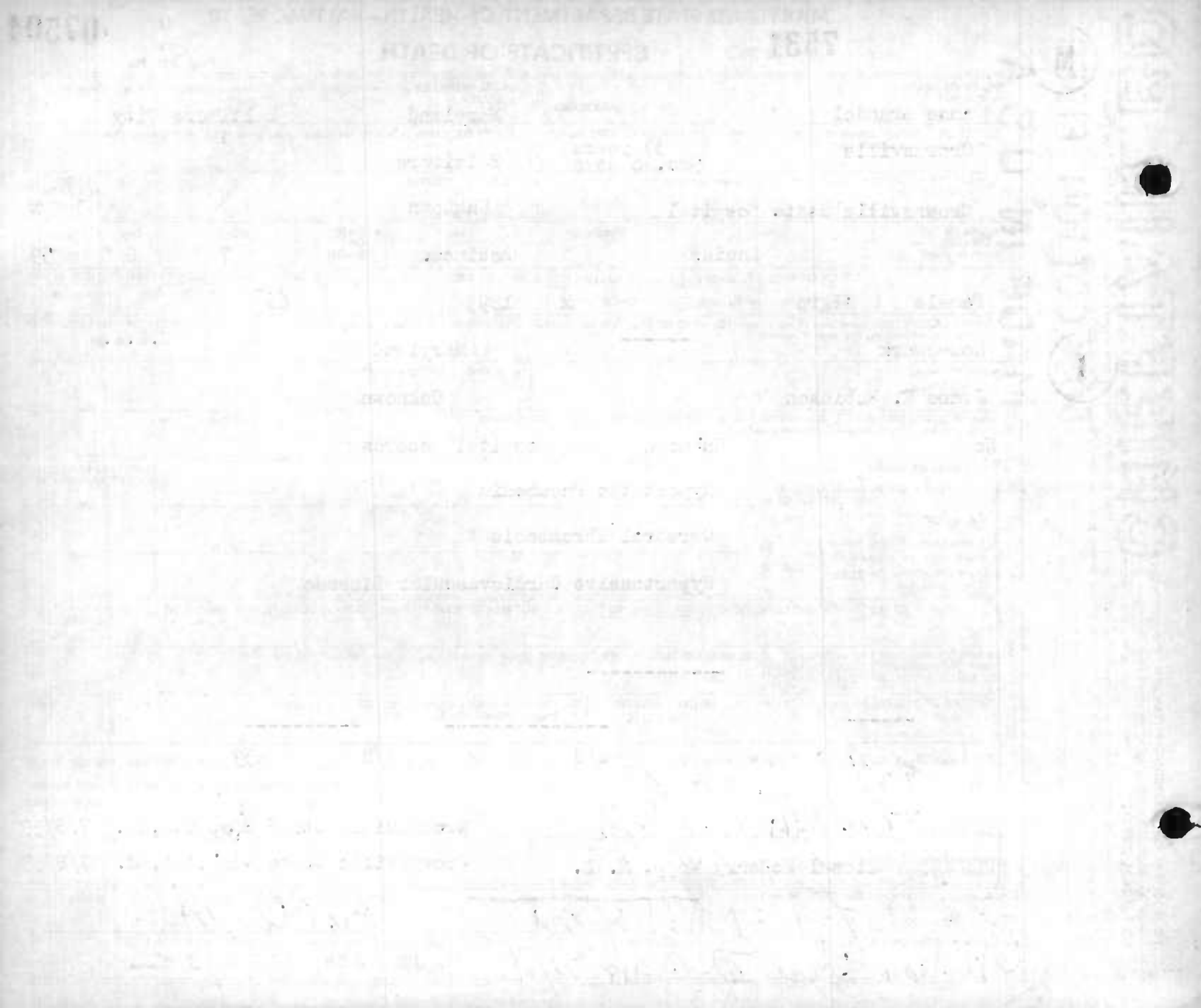
07504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crowsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>37 years 5mo. 6 days</b>				3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crowsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louise Robinson</b>				4. DATE OF DEATH Month Day Year <b>7 8 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1893</b>	
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James M. Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b> INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>443X</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> (c) <b>Hypertensive Cardiovascular Disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/2</b> , 19 <b>22</b> , to <b>7/8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/8</b> , 19 <b>59</b> , and that death occurred at <b>-----</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crowsville State Hospital, Md.</b> DATE SIGNED <b>7/8/59</b>							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> M.D.				PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal 7-9-59</b>				22b. DATE THEREOF <b>7-9-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>				22d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Anne. Md.</b>				24. REC'D BY REGISTRAR <b>JUL 10 '59</b>			
ADDRESS <b>-----</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 5.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 07506

FOR STATE  
HEALTH DEPT

### MEDICAL CERTIFICATION

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 2/57





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7532

CERTIFICATE OF DEATH

07507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>A. A. Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CLVATON Hgts</i>		c. LENGTH OF STAY IN 1b <i>6 yrs</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CLVATON Hgts</i>		d. STREET ADDRESS <i>Obrecht Rd Rt 1 Box 758A</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Obrecht Rd Rt 1 Box 758A</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HENRY J. SCHAEFER</i>		4. DATE OF DEATH <i>JULY 13 1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>17 NOV 1876</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SOLDIER (RET)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ENAMELING Co</i>	
11. BIRTHPLACE (State or foreign country) <i>BALTO MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>MD</i>	
13. FATHER'S NAME <i>HENRY SCHAEFER</i>		14. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>15-03-3083A</i>	
17. INFORMANT <i>MARIE E. HEBLER</i>		Address <i>Obrecht Rd Rt 1 Box 758A</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>several years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October 15, 1953</i> , to <i>July 13, 1959</i> , that I last saw the deceased alive on <i>July 12, 1959</i> , and that death occurred at <i>8:15 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		M.D. <i>RF 08 Box 442 Pasadena, Md</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		DATE SIGNED <i>July 13, 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>16 JULY 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>RODOLPH PARK CEM</i>		22d. LOCATION (City, town, or county) (State) <i>BALTO MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Not to be signed by B. M. Walters</i>		ADDRESS <i>PAH &amp; Spitzer</i>	
24a. REC'D BY REGISTRAR <i>14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	



7488

## CERTIFICATE OF DEATH

07508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Oliver</b> Middle Last <b>SELLMAN</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 24, 1900</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Clay Sellman</b>				14. MOTHER'S MAIDEN NAME <b>Roscoe Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-01-0604</b>		INFORMANT <b>Arthur Sellman</b> Address <b>104 College Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Stomach with</b> DUE TO <b>Metastases to Liver, Regional</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Roche Medical of Long Island City</b> DUE TO <b>Pulmonary Edema due to long standing heart failure</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10, 19 59</b> , to <b>July 14, 19 59</b> that I last saw the deceased alive on <b>July 14, 19 59</b> , and that death occurred at <b>3:40AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>110 Clay St., Annapolis, Md.</b> DATE SIGNED <b>7/15/59</b>							
ACTUAL SIGNATURE <b>Raymond L. Richardson</b>				PHYSICIAN'S NAME (Type) <b>Raymond L. Richardson</b> <b>Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-19-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Lothian Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Reese #108 Wash. St. Annapolis, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

82788

STATE OF TEXAS

1888

1888

County of \_\_\_\_\_

State of \_\_\_\_\_

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
BM 2/57

7533

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold.</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 75</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. BERTHA JOSEPHINE SHOWE</u>				4. DATE OF DEATH Month Day Year <u>July 4 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/88</u>	9. AGE (In years - last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Henry Switzer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Josephine Lawrence</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Mrs. Jean Wm. SHOWE (Sow)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>241X</u> DUE TO <u>Chronic Bronchial Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>431</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				DATE SIGNED <u>7/4/59</u>			
EXAMINER'S NAME (Type) <u>GUSTAVE H. FAUBERT-M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. D Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

MEDICAL CERTIFICATION

2

ep





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7489  
CERTIFICATE OF DEATH

07510

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		/d. STREET ADDRESS <b>X Galesville</b>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Mae</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 3, 1887</b>
9. AGE (In years lost birthday) yrs. <b>71 1/2</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Kirchnar</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Joyce</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Ernest H. Smith- Husband- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with brain hemorrhage</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 3</b> , 19 <b>59</b> , to <b>July 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 18</b> , 19 <b>59</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Emily H. Wilson</b>		M.D. <b>Lothian, Md.</b> DATE SIGNED <b>7/20/59</b>	
PHYSICIAN'S NAME (Type) <b>Emily H. Wilson</b>		<b>Lothian, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 21, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodfields Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Galesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

Name of Deceased		Date of Birth		Sex	
John Doe		12-15-1925		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		12-15-1925		Heart Disease	
Occupation		Signature of Physician		Signature of Registrar	
Teacher		[Signature]		[Signature]	
Manner of Death		Date of Burial		Place of Burial	
Natural		12-15-1925		Cemetery	
Name of Informant		Relationship to Deceased		Signature of Informant	
John Doe		Son		[Signature]	
Address of Informant		Date of Statement		Signature of Registrar	
123 Main St		12-15-1925		[Signature]	
City		State		County	
New York		New York		New York	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7490

### CERTIFICATE OF DEATH

07511

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>1200 West St.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Thomas A SMITH Sr</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>July 14 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 19, 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor &amp; Bldg.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Masonry Cont.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Thomas Smith</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Katherine Rogers Smith</u> Address <u>(2)</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma toxic</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Gall Bladder</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>9 wks.</u> <u>4 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>April 5, 1958</u> to <u>7-14-1959</u> , that I lost s/he the deceased alive on <u>7-14-1959</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Martin</u>				ADDRESS (Street, city or town, state) <u>6 Shaw St.,</u>		DATE SIGNED <u>7/15/59</u>	
PHYSICIAN'S NAME (Type) <u>James R. Martin</u>				<u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Sayles</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Calvin E. Evans</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 4 Film G244 7-17-59 et  
7534  
CERTIFICATE OF DEATH

07512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	c. LENGTH OF STAY IN 1b <u>10 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LAUREL MD ROUTE 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>FORT MEADE ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>SPRUELL</u> Last <u>SPRUELL</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 14, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAID</u>	
11. BIRTHPLACE (State or foreign country) <u>WARREN CO. N. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN SPRUELL</u>		14. MOTHER'S MAIDEN NAME <u>NANCY BOYD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>238-76-7047</u>	
17. INFORMANT <u>ELIZA HOLMAN. ROUTE 1, BOX 160 LAUREL MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure.</u> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiac failure.</u> DUE TO (c) <u>cardiac failure.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-25</u> , 19 <u>59</u> , to <u>7-11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-6</u> , 19 <u>59</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Pololo S. Alexandri</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROANOKE CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>WELDON N. CAROLINA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Colburn &amp; Hume</u>			

11000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
PLACE OF BIRTH  
DATE OF BIRTH  
SEX  
AGE  
RACE  
RELIGION  
MARRIAGE  
EDUCATION  
OCCUPATION  
PREVIOUS ILLNESS  
PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL  
PREVIOUS TOBACCO  
PREVIOUS OTHER

1. Name of deceased		2. Sex		3. Age		4. Race		5. Religion		6. Marriage		7. Education		8. Occupation		9. Previous illness		10. Previous surgery		11. Previous trauma		12. Previous drugs		13. Previous alcohol		14. Previous tobacco		15. Previous other											
16. Date of death		17. Place of death		18. Cause of death		19. Manner of death		20. Place of birth		21. Date of birth		22. Sex		23. Age		24. Race		25. Religion		26. Marriage		27. Education		28. Occupation		29. Previous illness		30. Previous surgery		31. Previous trauma		32. Previous drugs		33. Previous alcohol		34. Previous tobacco		35. Previous other	
36. Signature of physician		37. Signature of registrar		38. Signature of witness		39. Signature of witness		40. Signature of witness		41. Signature of witness		42. Signature of witness		43. Signature of witness		44. Signature of witness		45. Signature of witness		46. Signature of witness		47. Signature of witness		48. Signature of witness		49. Signature of witness		50. Signature of witness		51. Signature of witness		52. Signature of witness		53. Signature of witness		54. Signature of witness		55. Signature of witness	
56. Date of death		57. Place of death		58. Cause of death		59. Manner of death		60. Place of birth		61. Date of birth		62. Sex		63. Age		64. Race		65. Religion		66. Marriage		67. Education		68. Occupation		69. Previous illness		70. Previous surgery		71. Previous trauma		72. Previous drugs		73. Previous alcohol		74. Previous tobacco		75. Previous other	
76. Signature of physician		77. Signature of registrar		78. Signature of witness		79. Signature of witness		80. Signature of witness		81. Signature of witness		82. Signature of witness		83. Signature of witness		84. Signature of witness		85. Signature of witness		86. Signature of witness		87. Signature of witness		88. Signature of witness		89. Signature of witness		90. Signature of witness		91. Signature of witness		92. Signature of witness		93. Signature of witness		94. Signature of witness		95. Signature of witness	
96. Date of death		97. Place of death		98. Cause of death		99. Manner of death		100. Place of birth		101. Date of birth		102. Sex		103. Age		104. Race		105. Religion		106. Marriage		107. Education		108. Occupation		109. Previous illness		110. Previous surgery		111. Previous trauma		112. Previous drugs		113. Previous alcohol		114. Previous tobacco		115. Previous other	
116. Signature of physician		117. Signature of registrar		118. Signature of witness		119. Signature of witness		120. Signature of witness		121. Signature of witness		122. Signature of witness		123. Signature of witness		124. Signature of witness		125. Signature of witness		126. Signature of witness		127. Signature of witness		128. Signature of witness		129. Signature of witness		130. Signature of witness		131. Signature of witness		132. Signature of witness		133. Signature of witness		134. Signature of witness		135. Signature of witness	
136. Date of death		137. Place of death		138. Cause of death		139. Manner of death		140. Place of birth		141. Date of birth		142. Sex		143. Age		144. Race		145. Religion		146. Marriage		147. Education		148. Occupation		149. Previous illness		150. Previous surgery		151. Previous trauma		152. Previous drugs		153. Previous alcohol		154. Previous tobacco		155. Previous other	
156. Signature of physician		157. Signature of registrar		158. Signature of witness		159. Signature of witness		160. Signature of witness		161. Signature of witness		162. Signature of witness		163. Signature of witness		164. Signature of witness		165. Signature of witness		166. Signature of witness		167. Signature of witness		168. Signature of witness		169. Signature of witness		170. Signature of witness		171. Signature of witness		172. Signature of witness		173. Signature of witness		174. Signature of witness		175. Signature of witness	
176. Date of death		177. Place of death		178. Cause of death		179. Manner of death		180. Place of birth		181. Date of birth		182. Sex		183. Age		184. Race		185. Religion		186. Marriage		187. Education		188. Occupation		189. Previous illness		190. Previous surgery		191. Previous trauma		192. Previous drugs		193. Previous alcohol		194. Previous tobacco		195. Previous other	
196. Signature of physician		197. Signature of registrar		198. Signature of witness		199. Signature of witness		200. Signature of witness		201. Signature of witness		202. Signature of witness		203. Signature of witness		204. Signature of witness		205. Signature of witness		206. Signature of witness		207. Signature of witness		208. Signature of witness		209. Signature of witness		210. Signature of witness		211. Signature of witness		212. Signature of witness		213. Signature of witness		214. Signature of witness		215. Signature of witness	
216. Date of death		217. Place of death		218. Cause of death		219. Manner of death		220. Place of birth		221. Date of birth		222. Sex		223. Age		224. Race		225. Religion		226. Marriage		227. Education		228. Occupation		229. Previous illness		230. Previous surgery		231. Previous trauma		232. Previous drugs		233. Previous alcohol		234. Previous tobacco		235. Previous other	
236. Signature of physician		237. Signature of registrar		238. Signature of witness		239. Signature of witness		240. Signature of witness		241. Signature of witness		242. Signature of witness		243. Signature of witness		244. Signature of witness		245. Signature of witness		246. Signature of witness		247. Signature of witness		248. Signature of witness		249. Signature of witness		250. Signature of witness		251. Signature of witness		252. Signature of witness		253. Signature of witness		254. Signature of witness		255. Signature of witness	
256. Date of death		257. Place of death		258. Cause of death		259. Manner of death		260. Place of birth		261. Date of birth		262. Sex		263. Age		264. Race		265. Religion		266. Marriage		267. Education		268. Occupation		269. Previous illness		270. Previous surgery		271. Previous trauma		272. Previous drugs		273. Previous alcohol		274. Previous tobacco		275. Previous other	
276. Signature of physician		277. Signature of registrar		278. Signature of witness		279. Signature of witness		280. Signature of witness		281. Signature of witness		282. Signature of witness		283. Signature of witness		284. Signature of witness		285. Signature of witness		286. Signature of witness		287. Signature of witness		288. Signature of witness		289. Signature of witness		290. Signature of witness		291. Signature of witness		292. Signature of witness		293. Signature of witness		294. Signature of witness		295. Signature of witness	
296. Date of death		297. Place of death		298. Cause of death		299. Manner of death		300. Place of birth		301. Date of birth		302. Sex		303. Age		304. Race		305. Religion		306. Marriage		307. Education		308. Occupation		309. Previous illness		310. Previous surgery		311. Previous trauma		312. Previous drugs		313. Previous alcohol		314. Previous tobacco		315. Previous other	
316. Signature of physician		317. Signature of registrar		318. Signature of witness		319. Signature of witness		320. Signature of witness		321. Signature of witness		322. Signature of witness		323. Signature of witness		324. Signature of witness		325. Signature of witness		326. Signature of witness		327. Signature of witness		328. Signature of witness		329. Signature of witness		330. Signature of witness		331. Signature of witness		332. Signature of witness		333. Signature of witness		334. Signature of witness		335. Signature of witness	
336. Date of death		337. Place of death		338. Cause of death		339. Manner of death		340. Place of birth		341. Date of birth		342. Sex		343. Age		344. Race		345. Religion		346. Marriage		347. Education		348. Occupation		349. Previous illness		350. Previous surgery		351. Previous trauma		352. Previous drugs		353. Previous alcohol		354. Previous tobacco		355. Previous other	
356. Signature of physician		357. Signature of registrar		358. Signature of witness		359. Signature of witness		360. Signature of witness		361. Signature of witness		362. Signature of witness		363. Signature of witness		364. Signature of witness		365. Signature of witness		366. Signature of witness		367. Signature of witness		368. Signature of witness		369. Signature of witness		370. Signature of witness		371. Signature of witness		372. Signature of witness		373. Signature of witness		374. Signature of witness		375. Signature of witness	
376. Date of death		377. Place of death		378. Cause of death		379. Manner of death		380. Place of birth		381. Date of birth		382. Sex		383. Age		384. Race		385. Religion		386. Marriage		387. Education		388. Occupation		389. Previous illness		390. Previous surgery		391. Previous trauma		392. Previous drugs		393. Previous alcohol		394. Previous tobacco		395. Previous other	
396. Signature of physician		397. Signature of registrar		398. Signature of witness		399. Signature of witness		400. Signature of witness		401. Signature of witness		402. Signature of witness		403. Signature of witness		404. Signature of witness		405. Signature of witness		406. Signature of witness		407. Signature of witness		408. Signature of witness		409. Signature of witness		410. Signature of witness		411. Signature of witness		412. Signature of witness		413. Signature of witness		414. Signature of witness		415. Signature of witness	
416. Date of death		417. Place of death		418. Cause of death		419. Manner of death		420. Place of birth		421. Date of birth		422. Sex		423. Age		424. Race		425. Religion		426. Marriage		427. Education		428. Occupation		429. Previous illness		430. Previous surgery		431. Previous trauma		432. Previous drugs		433. Previous alcohol		434. Previous tobacco		435. Previous other	
436. Signature of physician		437. Signature of registrar		438. Signature of witness		439. Signature of witness		440. Signature of witness		441. Signature of witness		442. Signature of witness		443. Signature of witness		444. Signature of witness		445. Signature of witness		446. Signature of witness		447. Signature of witness		448. Signature of witness		449. Signature of witness		450. Signature of witness		451. Signature of witness		452. Signature of witness		453. Signature of witness		454. Signature of witness		455. Signature of witness	
456. Date of death		457. Place of death		458. Cause of death		459. Manner of death		460. Place of birth		461. Date of birth		462. Sex		463. Age		464. Race		465. Religion		466. Marriage		467. Education		468. Occupation		469. Previous illness		470. Previous surgery		471. Previous trauma		472. Previous drugs		473. Previous alcohol		474. Previous tobacco		475. Previous other	
476. Signature of physician		477. Signature of registrar		478. Signature of witness		479. Signature of witness		480. Signature of witness		481. Signature of witness		482. Signature of witness		483. Signature of witness		484. Signature of witness		485. Signature of witness		486. Signature of witness		487. Signature of witness		488. Signature of witness		489. Signature of witness		490. Signature of witness		491. Signature of witness		492. Signature of witness		493. Signature of witness		494. Signature of witness		495. Signature of witness	
496. Date of death		497. Place of death		498. Cause of death		499. Manner of death		500. Place of birth		501. Date of birth		502. Sex		503. Age		504. Race		505. Religion		506. Marriage		507. Education		508. Occupation		509. Previous illness		510. Previous surgery		511. Previous trauma		512. Previous drugs		513. Previous alcohol		514. Previous tobacco		515. Previous other	
516. Signature of physician		517. Signature of registrar		518. Signature of witness		519. Signature of witness		520. Signature of witness		521. Signature of witness		522. Signature of witness		523. Signature of witness		524. Signature of witness		525. Signature of witness		526. Signature of witness		527. Signature of witness		528. Signature of witness		529. Signature of witness		530. Signature of witness		531. Signature of witness		532. Signature of witness		533. Signature of witness		534. Signature of witness		535. Signature of witness	
536. Date of death		537. Place of death		538. Cause of death		539. Manner of death		540. Place of birth		541. Date of birth		542. Sex		543. Age		544. Race		545. Religion		546. Marriage		547. Education		548. Occupation		549. Previous illness		550. Previous surgery		551. Previous trauma		552. Previous drugs		553. Previous alcohol		554. Previous tobacco		555. Previous other	
556. Signature of physician		557. Signature of registrar		558. Signature of witness		559. Signature of witness																																	



7491

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1½ months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Pasadena</b>	
		f. STREET ADDRESS <b>RFD-1</b>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>(Mary Estelle)</b> Last <b>STALLINGS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert L. Gray</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Boyd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Henry B. Stallings</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular disease</b> <b>422.1</b> DUE TO <b>Paralysis of heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>and after heart attack</b> DUE TO (c) <b>and after heart attack</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1959</b> to <b>July 17, 1959</b> that I last saw the deceased alive on <b>July 17, 1959</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>3 Chesapeake Ave.,</b> DATE SIGNED <b>7/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Elmer G. Linhardt</b>		<b>Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>20 July 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Meth. Ch. Cem. Mt. Rd. Pasadena, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Singleton - Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 21 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7535

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

07514

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		d. STREET ADDRESS <b>Route #1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lowell</b> Middle <b>Thomas</b> Last <b>Staubitz Jr</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 July 1959</b>
9. AGE (In years last birthday) <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lowell Thomas Staubitz</b>		14. MOTHER'S MAIDEN NAME <b>Carlenda Elizabeth Timmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mother</b>		Address <b>Mrs Lowell Thomas Staubitz, Sykesville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity, 32 weeks</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>776X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 July</b> , 19 <b>59</b> , to <b>9 July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9 July</b> , 19 <b>59</b> , and that death occurred at <b>1230P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Army Hospital, Ft Meade, Md</b> DATE SIGNED <b>9 Jul 59</b>			
ACTUAL SIGNATURE <b>Roger C. Moyer</b>		M.D. <b>U.S. Army Hospital, Ft Meade, Md</b>	
PHYSICIAN'S NAME (Type) <b>ROGER C. MOYER, CAPT, MC, US ARMY HOSPITAL, FT GEORGE G. MEADE, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-12-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Freedom</b>		22d. LOCATION (City, town, or county) (State) <b>Calderburg, Carroll, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Wright</b>		ADDRESS <b>Chesapeake, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur H. Wright</b>	



7492

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 83 x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>3025 N. Oakland</u>	
3. NAME OF DECEASED (Type or print) <u>DOROTHY SUMMERBELL</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/19</u>
9. AGE (In years lost birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry L Selby.</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Simms.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>William E Summerbell, 3025 N. Oakland St. Arl. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>17 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/5</u> , 19 <u>59</u> to <u>7/6</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>7/6</u> , 19 <u>59</u> and that death occurred at <u>12:55A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST</u> DATE SIGNED <u>7/6/59</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		<u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial.</u>	22b. DATE THEREOF <u>7/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Fort Myer.</u>	22d. LOCATION (City, town, or county) (State) <u>Virginia.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F Birch, s Sons</u>		ADDRESS <u>Wash. 7 D.C.</u>	24a. REC'D BY REGISTRAR <u>JUL 8 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Caribon S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 7536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNA ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. LENGTH OF STAY IN 1b <u>13 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) <u>Woodcliff Beach</u>		d. STREET ADDRESS <u>WOODCLIFF BEACH PINE WHIFF BEACH</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAUDE KEENER SWINDELL</u>		4. DATE OF DEATH Month Day Year <u>July 24 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/83</u>
9. AGE (In years last birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES WILSON KEENER</u>	
14. MOTHER'S MAIDEN NAME <u>MARY JANE LEWIS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Wm. C. MacMillan, 8416 Woodcliff Ct., Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> <u>sudden</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>7</u> Month, Day, Year <u>7 19</u> P. M. <u>PM</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>7/28/59</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7537

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

07517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orchard Beach</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orchard Beach</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1220 Riverside Dr.</b>		d. STREET ADDRESS <b>1220 Riverside Dr.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>G.</b> Last <b>TAAFE</b>		4. DATE OF DEATH Month <b>7</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-98</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>PA.</b>	
11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Taafe</b>		14. MOTHER'S MAIDEN NAME <b>Lena</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Flora Taafe</b>		Address <b>Orchard Beach Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the throat</b> DUE TO <b>148X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 22, 1959</b> , to <b>July 6, 1959</b> , that I last saw the deceased alive on <b>July 5, 1959</b> , and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.M. McLaughlin</b>		ADDRESS (Street, city or town, state) <b>RFDS Box 442 Pasadena, Md.</b>	
PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin</b>		DATE SIGNED <b>July 6, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Brooklyn, MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home</b>		ADDRESS <b>130 E Fort Ave</b>	
24a. REC'D BY REGISTRAR <b>JUL 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7538

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A.A.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>50 BROOKLYN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4509 RITCHIE HIGHWAY</b>		d. STREET ADDRESS <b>1 4509 RITCHIE HIGHWAY</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN O. TAYLOR</b>		4. DATE OF DEATH Month Day Year <b>7/20/59 19</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/7/75</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRODUCE DEALER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JACKSON TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE PARKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>FAMILY - SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO <b>Arterio-sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2-3 years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic hypertrophic arthritis (2)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/14</b> , 19 <b>59</b> , to <b>7/20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/20</b> , 19 <b>59</b> , and that death occurred at <b>7:20</b> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>HARRY DEIBEL</b> M.D.		ADDRESS (Street, city or town, state) <b>1226 Hanover St. Baltimore 30 Md</b>	
DATE SIGNED <b>7/21/59</b>			
PHYSICIAN'S NAME (Type) <b>HARRY DEIBEL M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		22b. DATE THEREOF <b>7/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>MCCULLY FUNERAL HOMES - 130 E. FORT AVE.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUL 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

*[The body of the document contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a table or list structure, but the characters are too light to transcribe accurately.]*

1018

1018



7539

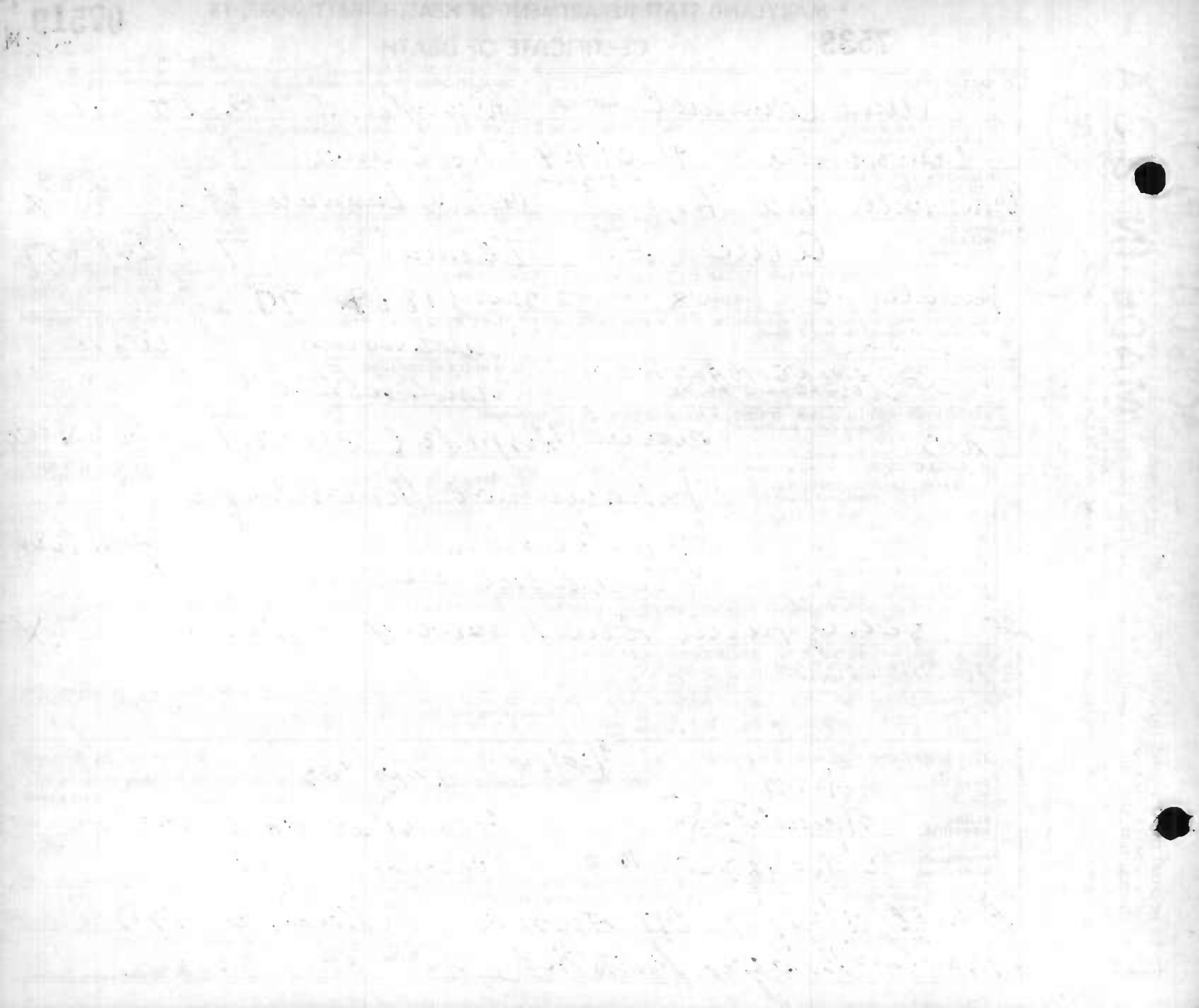
# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07519

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.-city</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hosp.</u> -5921-		d. STREET ADDRESS <u>1406 W Lanvale St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>F.</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>7</u> / Day <u>24</u> / Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>may 1889</u> 70 yrs.
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEVERING BANTHEM</u> <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA</u> <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital record. -Crownsville</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Cerebral embolus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>seizure React. undiff. type</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/20/59</u> , 19 <u>  </u> , to <u>7/24/59</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>7/24/59</u> , 19 <u>  </u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>CROWNVILLE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		<u>CROWNVILLE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT AUBURN</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO-MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mano P. P. [Signature]</u>		ADDRESS <u>Bethesda</u>	
24a. REC'D BY REGISTRAR <u>JUL 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

7540

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07520

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>	
c. LENGTH OF STAY IN 1b <u>3 yr. 11 da.</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Georgianna</u> Middle <u>(alias Thompson)</u> Last <u>Thomas</u>		<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>31</u> Year <u>19 59</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1892</u>
<b>9. AGE</b> (In years last birthday) <u>66</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>31</u> Hours <u>19</u> Min. <u>59</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Jimmy Jackson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Georgianna</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>	
<b>INFORMANT</b> <u>Hospital Records</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>443x</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>-</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>-</u> p. m. <u>-</u> 19 <u>59</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>-</u>		<b>20f. (City or town)</b> (County) (State) <u>-</u>	
<b>21. I certify</b> that I attended the deceased from <u>7/20</u> , 19 <u>56</u> , to <u>7/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> A. M. from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Lionel McHenry Mapp</u>		<b>DATE SIGNED</b> <u>7/31/59</u>	
<b>PHYSICIAN'S NAME</b> (Type) <u>Lionel McHenry Mapp, M.D.</u>		<b>ADDRESS</b> (Street, city or town, state) <u>Crownsville State Hosp., Md.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial Aug. 3, 59</u>		<b>22b. DATE THEREOF</b> <u>Aug. 3, 59</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Friendship Church</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Friendship Md. Co.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leroy E. Barry</u>		<b>ADDRESS</b> <u>Huntingtown, Md.</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>AUG 4 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Finner</u>	

03250

CERTIFICATE OF DEATH

2580



*[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CERTIFICATE OF DEATH

Reg. Dist. No.

07521

1. PLACE OF DEATH o. COUNTY <b>A. A. Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Ma.</b> b. COUNTY <b>AA Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ferndale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ferndale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>402 Melrose Rd.</b>		d. STREET ADDRESS <b>402 Melrose Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Albert H.</b> Middle <b>Thompson</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1890</b>
9. AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Produce</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>---Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>218 03 0131</b>	
17. INFORMANT (daughter) <b>Mrs. Alverta Gouldin</b>		Address <b>Ferndale Md. 402 Melrose Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR HEMORRHAGE</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL ATHEROSCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>15 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-25</b> , 19 <b>59</b> , to <b>7-20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-10</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leon C. Perry</b>		M.D. <b>201 B &amp; A BLVD</b>	
PHYSICIAN'S NAME (Type) <b>GLEN BURNIE,</b>		DATE SIGNED <b>7-21-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. 29, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. ...</b>		24a. REC'D BY REGISTRAR <b>Arthur S. ...</b>	
23. ADDRESS <b>4101 Edmondson Ave.</b>		24b. REGISTRAR'S SIGNATURE	

03581

CERTIFICATE OF DEATH

1933

402 Monroe St. 402 Monroe St. 402 Monroe St.

Albert H. Thompson 402 Monroe St. 402 Monroe St.

White 402 Monroe St. 402 Monroe St.

Thompson 402 Monroe St. 402 Monroe St.

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7493

## CERTIFICATE OF DEATH

07522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS <b>X Riva</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mabel Merrick Tilghman</b>				4. DATE OF DEATH Month Day Year <b>July 31 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1899</b>		9. AGE (In years last birthday) yrs. <b>60</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Registered Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Harford County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Annie Miles Riley</b>			
14. MOTHER'S MAIDEN NAME <b>Caleb M. Merrick</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT Address <b>Mr. Thomas O. Tilghman Sr. Husband asme as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Sunday</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/31/59</b> to <b>7/31/59</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Albert L. Anderson</b> M.D.				DATE SIGNED <b>7/31/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Albert L. Anderson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>AUGUST 2, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Southern Methodist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Dublin, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2483

07523

1. NAME OF DECEASED JAMES EARL RAY		2. SEX M		3. AGE 35		4. DATE OF BIRTH JAN 5, 1928		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION CONGRESSMAN		7. MARITAL STATUS M		8. EDUCATION H.S.		9. RELIGION METHODIST		10. RACE W	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. PLACE OF DEATH MEMPHIS, TENN.		14. DATE OF DEATH APR 4, 1968		15. TIME OF DEATH 4:00 PM	
16. SIGNATURE OF PHYSICIAN J. H. HARRIS		17. SIGNATURE OF REGISTRAR J. H. HARRIS		18. SIGNATURE OF WITNESS J. H. HARRIS		19. SIGNATURE OF WITNESS J. H. HARRIS		20. SIGNATURE OF WITNESS J. H. HARRIS	
21. SIGNATURE OF WITNESS J. H. HARRIS		22. SIGNATURE OF WITNESS J. H. HARRIS		23. SIGNATURE OF WITNESS J. H. HARRIS		24. SIGNATURE OF WITNESS J. H. HARRIS		25. SIGNATURE OF WITNESS J. H. HARRIS	
26. SIGNATURE OF WITNESS J. H. HARRIS		27. SIGNATURE OF WITNESS J. H. HARRIS		28. SIGNATURE OF WITNESS J. H. HARRIS		29. SIGNATURE OF WITNESS J. H. HARRIS		30. SIGNATURE OF WITNESS J. H. HARRIS	
31. SIGNATURE OF WITNESS J. H. HARRIS		32. SIGNATURE OF WITNESS J. H. HARRIS		33. SIGNATURE OF WITNESS J. H. HARRIS		34. SIGNATURE OF WITNESS J. H. HARRIS		35. SIGNATURE OF WITNESS J. H. HARRIS	
36. SIGNATURE OF WITNESS J. H. HARRIS		37. SIGNATURE OF WITNESS J. H. HARRIS		38. SIGNATURE OF WITNESS J. H. HARRIS		39. SIGNATURE OF WITNESS J. H. HARRIS		40. SIGNATURE OF WITNESS J. H. HARRIS	
41. SIGNATURE OF WITNESS J. H. HARRIS		42. SIGNATURE OF WITNESS J. H. HARRIS		43. SIGNATURE OF WITNESS J. H. HARRIS		44. SIGNATURE OF WITNESS J. H. HARRIS		45. SIGNATURE OF WITNESS J. H. HARRIS	
46. SIGNATURE OF WITNESS J. H. HARRIS		47. SIGNATURE OF WITNESS J. H. HARRIS		48. SIGNATURE OF WITNESS J. H. HARRIS		49. SIGNATURE OF WITNESS J. H. HARRIS		50. SIGNATURE OF WITNESS J. H. HARRIS	
51. SIGNATURE OF WITNESS J. H. HARRIS		52. SIGNATURE OF WITNESS J. H. HARRIS		53. SIGNATURE OF WITNESS J. H. HARRIS		54. SIGNATURE OF WITNESS J. H. HARRIS		55. SIGNATURE OF WITNESS J. H. HARRIS	
56. SIGNATURE OF WITNESS J. H. HARRIS		57. SIGNATURE OF WITNESS J. H. HARRIS		58. SIGNATURE OF WITNESS J. H. HARRIS		59. SIGNATURE OF WITNESS J. H. HARRIS		60. SIGNATURE OF WITNESS J. H. HARRIS	
61. SIGNATURE OF WITNESS J. H. HARRIS		62. SIGNATURE OF WITNESS J. H. HARRIS		63. SIGNATURE OF WITNESS J. H. HARRIS		64. SIGNATURE OF WITNESS J. H. HARRIS		65. SIGNATURE OF WITNESS J. H. HARRIS	
66. SIGNATURE OF WITNESS J. H. HARRIS		67. SIGNATURE OF WITNESS J. H. HARRIS		68. SIGNATURE OF WITNESS J. H. HARRIS		69. SIGNATURE OF WITNESS J. H. HARRIS		70. SIGNATURE OF WITNESS J. H. HARRIS	
71. SIGNATURE OF WITNESS J. H. HARRIS		72. SIGNATURE OF WITNESS J. H. HARRIS		73. SIGNATURE OF WITNESS J. H. HARRIS		74. SIGNATURE OF WITNESS J. H. HARRIS		75. SIGNATURE OF WITNESS J. H. HARRIS	
76. SIGNATURE OF WITNESS J. H. HARRIS		77. SIGNATURE OF WITNESS J. H. HARRIS		78. SIGNATURE OF WITNESS J. H. HARRIS		79. SIGNATURE OF WITNESS J. H. HARRIS		80. SIGNATURE OF WITNESS J. H. HARRIS	
81. SIGNATURE OF WITNESS J. H. HARRIS		82. SIGNATURE OF WITNESS J. H. HARRIS		83. SIGNATURE OF WITNESS J. H. HARRIS		84. SIGNATURE OF WITNESS J. H. HARRIS		85. SIGNATURE OF WITNESS J. H. HARRIS	
86. SIGNATURE OF WITNESS J. H. HARRIS		87. SIGNATURE OF WITNESS J. H. HARRIS		88. SIGNATURE OF WITNESS J. H. HARRIS		89. SIGNATURE OF WITNESS J. H. HARRIS		90. SIGNATURE OF WITNESS J. H. HARRIS	
91. SIGNATURE OF WITNESS J. H. HARRIS		92. SIGNATURE OF WITNESS J. H. HARRIS		93. SIGNATURE OF WITNESS J. H. HARRIS		94. SIGNATURE OF WITNESS J. H. HARRIS		95. SIGNATURE OF WITNESS J. H. HARRIS	
96. SIGNATURE OF WITNESS J. H. HARRIS		97. SIGNATURE OF WITNESS J. H. HARRIS		98. SIGNATURE OF WITNESS J. H. HARRIS		99. SIGNATURE OF WITNESS J. H. HARRIS		100. SIGNATURE OF WITNESS J. H. HARRIS	

OFFICE OF THE REGISTRAR  
BALTIMORE, MD

7494

## CERTIFICATE OF DEATH

07523

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U.S. General</u>		d. STREET ADDRESS <u>1317 First St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis Tompkins TOMASZEWski</u>		4. DATE OF DEATH Month Day Year <u>7-22 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4-1895</u> AGE (In years last birthday) <u>63</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Joiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Tomaszewski</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Lillian Tompkins (2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis / Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>VENTRICULAR TACHYCARDIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-6</u> , 19 <u>59</u> , to <u>7-22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-22</u> , 19 <u>59</u> , and that death occurred at <u>1:25</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S BECK</u>		DATE SIGNED <u>7/22/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. GOVERNMENT NAT. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BEVERLY N.J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>San Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased  
2. Age  
3. Sex  
4. Color  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of witness

11. Name of informant  
12. Address of informant  
13. Date of report  
14. Signature of informant  
15. Signature of registrar  
16. Signature of witness

7495

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port - Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C. A. General Hosp.</u>				d. STREET ADDRESS <u>403 Chesapeake Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence A. Turner</u>				4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-9-1911</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Acad</u>		11. BIRTHPLACE (State or foreign country) <u>East Port, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Solomon Turner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Blunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-267616</u>			
INFORMANT Address <u>Catherine Turner - East Port, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Vascular Disease</u> DUE TO (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/7</u> , 19 <u>59</u> to <u>7/29</u> , 19 <u>59</u> that I last saw the deceased alive on <u>7/29</u> , 19 <u>59</u> , and that death occurred at <u>12:30 A</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>7/30/59</u>			
PHYSICIAN'S NAME (Type) <u>DR. THEODORE H. JOHNSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

15251



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7542

CERTIFICATE OF DEATH

07525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carrollton Manor.</u>		c. LENGTH OF STAY IN 1b <u>x Carrollton Manor, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pte 3, Box 547 Severna Park.</u>		d. STREET ADDRESS <u>Knollwood Rid. Park</u>	
3. NAME OF DECEASED (Type or print) <u>Edwin McCellen Warren</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25 1904</u>
9. AGE (In years last birthday) <u>55</u>		10. IF UNDER 1 YEAR Months <u>35</u> Days <u>5</u> Hours <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Henberger</u>		14. MOTHER'S MAIDEN NAME <u>Truvelous</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-01-1986</u>	
17. INFORMANT <u>Wife</u>		Address <u>Severna</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema (Pulmonary)</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19, to <u>1959</u> , 19, that I last saw the deceased alive on <u>7-29-59</u> , 19, and that death occurred at <u>4 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>7-30-59</u>			
ACTUAL SIGNATURE <u>Robert Hahn, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Robert Hahn, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; KIRKLEY</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 31 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Glen Burnie, Md</u>		24c. REGISTRAR'S SIGNATURE <u>Charles S. K...</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
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49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7543

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07525

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eleonora</u> First <u>—</u> Middle <u>—</u> Last <u>Wilner</u>		4. DATE OF DEATH <u>7-30-1959</u> Month <u>7</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ROBERT E. SCAGGS</u>		14. MOTHER'S MAIDEN NAME <u>PETERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dean Williams</u> Address <u>Millersville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lobes Pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month <u>—</u> Day <u>—</u> Year <u>19</u> Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>June 1-59</u> to <u>July 30-59</u> , that I last saw the deceased alive on <u>July 29-59</u> , and that death occurred at <u>530 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Joseph Lipsky</u>		DATE SIGNED <u>7/30-59</u>	
PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKY</u>		ADDRESS (Street, city or town, state) <u>Odenton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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EXHIBIT 100-100000

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PAINE A. GINDEL  
MAY 1943  
HAROLD HARRIS

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MARYLAND

PETERS

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>184 Duke of Gloucester</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>E.</b> Last <b>WINCHESTER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1889</b>	
9. AGE (In years lost birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Patrick Lamb</b>				14. MOTHER'S MAIDEN NAME <b>Budget Hogan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Francis O. Winchester</b> Address <b>(2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Septicemia</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Chronic glomerular nephritis</b> (c) <b>arteriosclerosis generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1 yr.</b> <b>4 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January</b> , 1955, to <b>July 28</b> , 1959, that I last saw the deceased alive on <b>July 28</b> , 1959, and that death occurred at <b>5:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Shaw St., Annapolis, Md.</b> DATE SIGNED <b>7/29/59</b>							
ACTUAL SIGNATURE <b>James R. Martin</b>				PHYSICIAN'S NAME (Type) <b>James R. Martin</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>July 31-59</b>		<b>St Mary's Cent</b>		<b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>				ADDRESS <b>Annapolis Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 30 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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HEALTH OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G246 7-31-59 et

7544

CERTIFICATE OF DEATH

07528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville 2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seven</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sauns Nursing Home</b>		d. STREET ADDRESS <b>Maryland Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Ruth N. Wooden</b>		4. DATE OF DEATH <b>July 24 1959</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 Aug. 1909</b>
9. AGE (In years last birthday) <b>49</b>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. Wife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11c. BIRTHPLACE (State or foreign country) <b>Extra Johnston, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Howard W. Walton</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Leightner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wilbur E. Wooden</b>		Address <b>Seven Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub Arterial Hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO <b>Sclerotic Cardio Vascular Disease</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1959</b> to <b>July 23, 1959</b> , that I last saw the deceased alive on <b>July 23, 1959</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Febus Gruenberg</b> M.D.		ADDRESS (Street, city or town, state) <b>P.O. Box 27 Odenton, Md</b>	
DATE SIGNED <b>7/24/1959</b>			
PHYSICIAN'S NAME (Type) <b>Febus Gruenberg</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>27 July 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. Long, Jr.</b> ADDRESS <b>Glen Burnie Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneel</b>			

*Journal of Management Education* 30(6)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7497 Item 8 Film G244 7-21-59 et CERTIFICATE OF DEATH

07529

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;">MARYLAND</span> <b>Anne Arundel</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="float: right;">b. COUNTY</span> <b>Maryland</b> <span style="float: right;"><b>Anne Arundel</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>10</b> <b>Annapolis</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>			d. STREET ADDRESS <b>731 Glenwood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Sarah</b> Middle <b>ZELKOWITZ</b> Last <b>ZELKOWITZ</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>10</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>November 15, 1876</b>	<b>9. AGE</b> (In years last birthday) <b>92</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House wife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Russia</b>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>							
<b>13. FATHER'S NAME</b> <b>Unknown Block</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>INFORMANT</b> <b>Hospital Records</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concussion heart failure</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 yr.</b> <b>5 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>19</b> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <b>July 4, 1959</b> , <b>to</b> <b>July 10, 1959</b> , <b>that I last saw the deceased alive on</b> <b>July 10, 1959</b> , <b>and that death occurred</b> <b>12:35 PM</b> , <b>from the causes and on the date stated above.</b> <div style="text-align: right;">ADDRESS (Street, city or town, state) <b>121 Cathedral St., Annapolis, Maryland</b> DATE SIGNED <b>7/11/59</b></div>							
<b>ACTUAL SIGNATURE</b> <i>John Hedeman</i>		<b>PHYSICIAN'S NAME (Type)</b> <b>John Hedeman</b>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>July 12, 1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Kneseth Israel Cemetery</b>			
<b>22d. LOCATION</b> (City, town, or county) (State) <b>Annapolis, Maryland</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Hopping Funeral Home</i>		<b>ADDRESS</b> <b>Annapolis, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 16 '59</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1937

Date of death

Place of death

Time of death

Signature of

Signature of

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